Senate Select Committee on

MEDICAID REFORM

Lisa Carlton, Chair
Jeffrey Atwater, Vice Chair

This packet contains general comments submitted to members of the Senate Select Committee on Medicaid Reform and the House Select Committee on Medicaid Reform.

TAYLOR RESIDENCES

(1)

Taylor Home • Taylor Apartments • Taylor Care Center • Taylor Manor • Taylor Villas

JAMES T. RICE
Chief Executive Officer & Chief Financial Officer

March 14, 2005

To: Senate and House Committees on Medicaid Reform

I am Jim Rice, the Chief Executive Officer and Chief Financial Officer of Taylor Residences in Jacksonville. Taylor Residences consists of four 501(c)-3 facilities providing housing and service to approximately 700 elderly of our community. Included in these four operations are 144 nursing home beds (NH) and 185 rooms for assisted living (ALF). The NH beds maintain a Medicaid beneficiary rate close to 70%. 80 of the ALF rooms are within a HUD 236 facility and at the present time 30 of the ALF residents in these rooms are participating in the Medicaid Waiver or Medicaid Diversion programs. A total of 262 of our 344 apartments are HUD financed. **What happens to Medicaid is of vital interest to a majority of the people we serve.**

Our concern is **HERE AND NOW.** Our **RESIDENTS,** particularly **IN THE NH BEDS,** are **HERE NOW** and **MUST BE TAKEN CARE OF NOW. THEY WILL BE GONE BEFORE THE STATISTICS BEING PROVIDED FOR FUTURE COSTS TURN OUT TO BE RIGHT OR MORE LIKELY WRONG.**

Why are we concerned about the outcome of Medicaid Reform? There are a variety of reasons, including current experience with Medicaid reimbursement. When we reach the point where the State is cutting dietary budgets for NH residents, ($34,000 at Taylor Care Center based on the January 1, 2005 Medicaid Reimbursement rate) no one knows what to expect, but the signs are not good. Now another major and deeply troubling issue is being floated entitled, "conflict of interest." This develops from the concept of a for-profit "managed care organization" being given the authority to negotiate the amount of money to be paid to providers for services.

If my understanding is correct, the MCO will receive a rate per person managed and then will make the decisions relative to the services received by that individual. Since making a profit is essential to such MCO's, it does not take a brain surgeon to figure out where ultimately the services will be provided-- at the lowest cost level. There goes quality of care and dignity for the elderly. In fact the Agency for Health Care Administration will be able to be renamed the Agency for Health Care Contracts, dispose of its oversight group, the surveyors, and add to the curtailment of future costs of Medicaid.

Beginning in 2000, I have appeared before the Duval Delegation annually to discuss the gravity of the Medicaid reimbursement situation, in particular as it relates to the liability insurance situation and to the State's failure to cover the costs of mandated services that

we must provide in our nursing facilities. In addition, I have met with a number of the members of this panel and made appearances at several Legislative hearings. Always included in my comments have been suggestions to help reign in costs. Unfortunately none of these suggestions have yet to be implemented.

Our nursing facilities continue to suffer from the failure of the Legislature to rebase the general and operating component of the Medicaid reimbursement rate. Talk is made about future costs, yet current costs are not being appropriately handled. There still remains no relief from the upward spiral of liability insurance premiums that occurred between 2000 and 2002. In other words, tort reform of 2001 has failed! The shortage in the labor market for nurses and certified nursing assistants is still a problem. **Yet it is also noted that several new nursing facilities have been allowed to open in Jacksonville, despite the moratorium on new beds. The rate of one of the new nursing homes had a July 1, 2004 Medicaid reimbursement rate that was 7.6% higher than the Care Center's rate.**

The Legislature needs to correct the Medicaid reimbursement problem in a manner that does not harm residents. **Fortunately, the State has recognized it cannot afford to pay for further staff increases, and has been deferring any increases for certified nursing assistants above the 2.6 ratio.** This is appropriate.

Other ways to address the economic issues associated with Medicaid are denoted below:

1. **Maintain and extend the moratorium on any new nursing home beds**. Since 2001 there has been a numerical decrease in available beds and this, coupled with the population increase, has produced an even larger percentage decrease.

2. **Change the rule for disposing of personal assets to qualify for Medicaid from three years to five years or longer.**

3. **Place more emphasis on the State withdrawing licensure from mediocre facilities that provide lousy service**. This would accelerate the reduction in available beds and assist in reducing the risk exposure for insurance companies.

4. Because the Feds require Florida not to impose any residency requirement for Medicaid eligibility**, Congress should be urged to change the existing formula for distribution of Medicaid funds**. Perhaps eligibility time restrictions on moving across state lines should be imposed just as time restrictions for disposing of assets exist.

5. Consider what can be done by government to **encourage the expansion of long-term care insurance** that was never available to most whom currently reside in nursing homes.

6. **Support and expand the ALF Medicaid Waiver program** (not to be confused with the Medicaid Nursing Home Diversion program that I believe should be eliminated). **The Waiver program has worked well, saved the State money, and is not difficult to administer. Improvements can be made in the program that would further reduce**

administrative costs. Specifically, the Waiver program should be a subset of the regular Medicaid process and not completely independent.

7. As noted above, **eliminate the NH "diversion" efforts** that now account for a significant part of the budget. In my opinion, the "diversion" program is ill advised and based upon faulty premises. At worse, it is premature, and at best, it inflicts considerable harm on current residents in nursing homes. **Its need is highly questionable in view of the current moratorium on new nursing home beds and the ALF Medicaid Waiver program that has proved to be quite effective**. The "diversion" program has interjected another level (or levels) of administrative costs into the system that must be absorbed from funds otherwise used for beneficiaries. It has also created a monstrous conflict of interest for those under contract to run the program.

8. **Require ALL governmental (federal or state) mandates to be subjected to cost-benefit analysis**. HIPAA should have been subjected to this test. Had it been, or should it be, it would not be allowed to continue.

Please call upon me to expand upon any of these points. Also, take the opportunity to visit us at Taylor where you can see what we do and meet those we serve.

Sincerely,

James T. Rice

Association of Florida Children's Hospitals, Inc.

A Council of the Florida Hospital Association

MEMO

To: Florida Senate and House Select Committee on Medicaid Reform

From: Albert H. Wilkinson, Jr., M.D.
Immediate Past President, Association of Florida Children's Hospitals

Date: March 14, 2005

Subject: Medicaid Reform

Thank you for this meeting and the opportunity to make this presentation.

1. The Association of Florida Children's Hospital's recognizes the need to accomplish efficiencies in the Medicaid program to reduce cost while maintaining quality.

2. Children's hospitals provide essential in-hospital care for 55% of children who require hospitalization, and these are the most seriously ill of all.

3. Children's hospitals provide essential training for current and future pediatricians.

4. Current Medicaid reimbursements are less than hospital costs of care.

5. Early and adequate hospital care for children with major medical problems will reduce later costs.

6. No child is refused care because of inability of the parent or guardian to pay, but none of the Florida children's hospitals are significantly endowed to offset such costs altogether.

7. In reforming Medicaid, it must be considered that these twelve children's hospitals in Florida are the essential safety nets in children's healthcare.

Thank you for again for the opportunity to be heard. Please refer to the accompanying attachments.

Association of Florida Children's Hospitals, Inc.

A Council of the Florida Hospital Association

Member Hospitals provide the care for over 55% of all pediatric Medicaid patient days and over 53% of pediatric patient days in Florida. The vast majority of chronically ill children in the state of Florida are cared for by these children's hospitals.

- All Children's Hospital, St. Petersburg
- Arnold Palmer Hospital for Children and Women, Orlando
- Baptist Children's Hospital, Miami
- Children's Hospital at Sacred Heart, Pensacola
- The Children's Hospital of Southwest Florida, Ft. Myers
- Chris Evert Children's Hospital at Broward General Medical Center, Ft. Lauderdale
- Holtz Children's Hospital at UM/Jackson Memorial Medical Center, Miami
- Joe Di Maggio Children's Hospital, Hollywood
- Miami Children's Hospital, Miami
- Shands Children's Hospital at the University of Florida, Gainesville
- St. Joseph's Children's Hospital of Tampa, Tampa
- Wolfson Children's Hospital, Jacksonville

In 1999, the Association of Florida Children's Hospitals was organized to enhance and improve children's healthcare in Florida. This collaborative effort of children's hospitals seeks to accomplish this mission by focusing on the following areas:

- *Patient Care* – by sharing knowledge of efficiencies, methods, new technologies and legislative needs
- *Education* – by promotion of educational efforts for physicians, allied healthcare professionals, families and patients
- *Research* – by promoting and sharing efforts in state, national, and international participation in clinical and basic programs
- *Child Advocacy* – by providing a voice for our young citizens to ensure their health and well being throughout the state of Florida

Through the sharing and dissemination of knowledge, information, experiences, and research, the AFCH encourages the development of the most effective means of delivering comprehensive healthcare to the children of Florida.

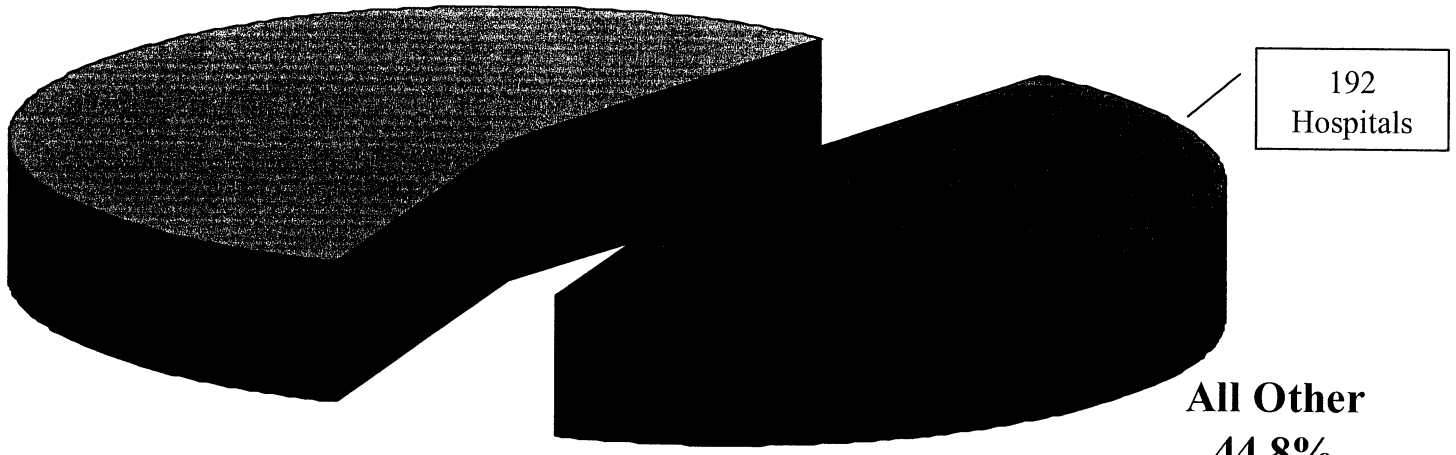
Association of Florida Children's Hospitals, Inc.

2003 Pediatric Medicaid Patient Day Volume* & Percent of Florida Medicaid Pediatric Patient Days

AFCH Total Patient Days - 280,024

Total Patient Days - 507,219

AFCH Members
55.2%



All Other
44.8%

***All medical/surgical pediatric (0-17) and neonatal patients excluding normal newborns, psychiatric and obstetric patients.**

Source: MedStat/AHCA Database

Association of Florida Children's Hospitals, Inc.

Medicaid - Good Medicine for Florida's Economy

Spending on Medicaid has a significant impact on Florida's economy.

Efforts to re-structure the Florida Medicaid program must consider that Medicaid dollars play a critical role in stimulating business activity in the state of Florida.

Consider the following facts:

• Medicaid is a state federal partnership. Every $1 the state spends on the Medicaid program generates an additional $1.43 in federal money - new dollars that would not otherwise flow into this state.

• Cuts in Medicaid benefits and eligibility do not reduce health care costs. For every $1 we cut in Medicaid costs, we lose 60 cents in federal funding. Since the need for care remains, the full cost is now shifted to local taxpayers, employers, hospitals and the privately insured.

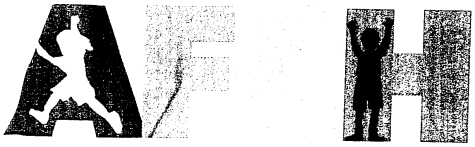
The Multiplier Effect on Florida's Economy:

• Medicaid dollars flowing into Florida's economy have a "multiplier effect." Thus the aggregate impact of Medicaid spending on the state's economy is greater than the value of the services purchased directly by the Medicaid program. New economic activity generated by Medicaid spending includes new business activity (increased output of goods and services), new jobs and associated wages.

• In fiscal year 2005, Florida will spend approximately 5.5 billion in state funding for its Medicaid program. This investment in Medicaid will generate more than a three fold return in state economic benefit.

•In fiscal year 2005 state Medicaid matching dollars will support 174,000 new jobs, 6.5 billion in wages and 16.8 billion in business activity. These jobs will include Medicaid personnel, other employment in the health sector and jobs generated as the Medicaid dollars circulate through different sectors of the economy.

Adapted from *Medicaid: Good Medicine for State Economies, 2004 Update,* A Report by Families U.S.A., May 2004, available at www.familiesusa.org. and *Penny Wise & Pound Foolish, Why Cuts to Medicaid Hurt Florida's Economy*, Oct. 2003, a report by the Human Services Coalition of Dade County and Treasure Coast CHAIN available at http://www.floridachain.org/pubs/MedcaidReport.pdf



Association of Florida Children's Hospitals, Inc.

A Council of the Florida Hospital Association

The Association member hospitals provide the care for over 55% of all pediatric Medicaid patient days and over 53% of pediatric patient days in Florida. The vast majority of chronically ill children in the state of Florida are cared for by these children's hospitals. Member Hospitals also provide care for the vast majority of chronically ill children in the state of Florida. Through the sharing and dissemination of knowledge, information, experiences, and research, the AFCH encourages the development of the most effective means of delivering comprehensive healthcare to the children of Florida.

AFCH Guiding Principles for Florida Medicaid Reform

Medicaid is the key health care safety net program for Florida's families, providing vital health care services to nearly 2.2 million children, pregnant woman, seniors, and people with severe disabilities. According to the Agency for Health Care Administration (AHCA) Medicaid covers 27% of Florida's children who, in turn, comprise 53.30% of all Medicaid enrollees. Conversely, only 17.65% of Medicaid expenditures are attributed to these children.

In addition to meeting the health care needs of our state's most vulnerable residents, Florida's Medicaid program helps to strengthen our state's economy. Specifically, state Medicaid matching dollars have directly supported 174,000 jobs, $6.5 billion in wages and $16.8 billion in business activity for FY 2005.[1] As the Governor, state legislature and federal officials evaluate proposals for restructuring the Florida Medicaid program, it is important to protect the core elements of this safety net program.

Over the past five years, Florida has historically been a leader and has made significant inroads into reducing the number of uninsured children through expansions of Medicaid and KidCare to children up to 200% of the federal poverty level. But recent program changes that prevent eligible, uninsured children from receiving KidCare are reversing our progress. Medicaid reform must avoid further reductions in eligibility, simplify enrollment and retention procedures in all of the KidCare programs, including Medicaid and Healthy Kids, and ensure true access to all necessary medical services.

Moreover, Medicaid reform initiatives must focus on improving the quality of health care services provided to Medicaid consumers. This should include technology enhancements, data compilation and publication to document improved outcomes.

AFCH strongly urges policy makers to consider the following principles in any effort to reform the Medicaid program:

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[1]Families U.S.A. *Medicaid: Good Medicine for State Economies, 2004 Update*

River Garden
HEBREW HOME/WOLFSON HEALTH & AGING CENTER
Governor's Gold Seal Award for Excellence in Long Term Care

RONALD ELINOFF
President
MARTIN A. GOETZ, MS, MPA
Chief Executive Officer
BETTY S. SORNA, CPA, MAcc
Senior Associate Administrator/CFO
ELLIOTT PALEVSKY, MA
Senior Executive Director

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Testimony to Joint Senate / House Committee on Medicaid Reform

Jacksonville, Florida

Monday, March 14, 2005

Martin A. Goetz

Dear Senator Carlton, Representative Negron, and members of the Joint Select Committee on Florida Medicaid Reform:

My name is Martin Goetz and I am the Executive Director and Chief Executive Officer of the not-for-profit River Garden Hebrew Home, a two-time recipient of the Governor's Gold Seal Award for Excellence in Long-Term Care. I also chair the Nursing Home Public Policy Committee of FAHA – the not-for-profit Florida Association of Homes for the Aging. While I suspect that much of what I am talking about today regarding Medicaid Reform has been discussed in one of your previous stakeholder meetings, it is important that fundamental concerns around cost, access, and quality be addressed and reaffirmed to the Legislature.

We are grateful to the Florida Legislature in insisting that the Governor's Medicaid Reform proposal be slowed down so that you have opportunity for significant consideration of the issues of public well-being involved in any fundamental revamping of the current program. We are told that what drives the Governor's Medicaid Modernization Plan is runaway dollars in the program, along with a fundamental desire to reduce that which Floridians are paying through tax dollars toward programs of social well-being. Over 2.2 million Floridians depend on Medicaid for their health care. The lions share of funding goes to the elderly and disabled, followed by children. Medicaid reform cannot (should not) be taken lightly because of the number of people who can be hurt. We need to be clear in understanding that any effort at systemic reform and expansion of options under a managed care program requires an initial expansion of budget with savings to be realized over the longer run. Yet, the announced agenda here is to cap and contract budget going forward.

Before the Executive and Legislative branches of government make wholesale changes to the existing Medicaid Program, recognize that there are forces already at work that will significantly reduce projected costs in the Florida Medicaid Program.

1. **Nursing Home Moratorium:** In May 2001 the Legislature imposed a five year moratorium on construction of new nursing home beds. This moratorium will expire in 2006 and we suggest that it be continued for another five years, ending in 2011. Doing so will allow the continued development of outpatient community based resources for

elderly and infirm Floridians who can be cared for in less restrictive settings while at the same time allowing for continued development of nursing home diversion programs. It is important to note that during the last 14 years, Florida has added almost 17,000 nursing home beds, a 26 percent increase in supply. At the present time, Florida has 668 nursing homes representing 81,980 beds. Projections in caseload growth in the institutional Medicaid budget do not properly recognize the continued effects of this moratorium. It is impossible to accurately project Medicaid costs going forward without giving the state budget a credit for growth in nursing home beds that is not going to occur.

2. **Nursing Home Medicaid Cuts:** At the same time, it is necessary to adequately and responsibly fund the cost of care for those elderly and infirm Floridians who are most needful for institutionalized long-term care. Last session, the Legislature removed $67 million from Medicaid Budget. For River Garden, that reduction resulted in an additional projected shortfall of $150,000. As a not-for-profit community agency that already subsidizes indigent care by over $1 million annually, the Legislature left us with no alternative but to significantly reduce our participation in the Medicaid Program. And so there is now an average of ten less Medicaid residents receiving care at River Garden this year than last. As painful as this was to us we simply had no alternative because we are committed to not degrading care programs. The Governor's next budget includes $200 million in proposed cuts to nursing home Medicaid funding. This will represent another $300,000 on top of the already mentioned $1 million we subsidize the care of Medicaid residents, and if approved by the Legislature will leave River Garden with no choice but

to further reduce its participation in the Medicaid Program. If this proposal passes the Legislature nursing homes such as River Garden that are consistently referred to as among the finest in the state will be unable to serve Florida's Medicaid clients, and the Legislature will have created a two tier system of services with significantly different levels of care. Please do not allow this to occur.

3. **Medicaid Abuse:** There are any numbers of Florida based businesses that operate with the primary purpose of qualifying otherwise ineligible Medicaid applicants. This is accomplished by exploiting unintended loopholes in the existing Medicaid program, such as through "Medicaid Annuities." River Garden recently rejected an application for admission to the Home from a family whose son had engaged a local elder care attorney to create an allowable Medicaid annuity for his mother thereby making his otherwise middle class and asset rich mother eligible for Florida Medicaid. We told the son through his attorney that we wouldn't admit his mother under these circumstances, that while what they are doing may well be legal it is certainly not in keeping with the spirit or intent of the Medicaid Program. The son placed his mother in another facility. We urge the Legislature to close these legislative loopholes which enable otherwise ineligible Floridians to qualify for Florida Medicaid benefits. I've attached submittal literature on one such company.

4. **Managed Care:** There is nothing inherently wrong with managed care organizations (MCO). But managed care done properly will initially increase, not decrease Medicaid program costs. There can be savings realized over the longer run per one thousand of

covered frail elderly clients thanks to the positive effects of "just in time" low cost interventions and expansion of community based services. These can delay and in some cases avoid the need for institutional care. At the same time, people are deflected from nursing home care, those for whom it is the only appropriate response will, on average, require more costly care requiring commensurate increases in nursing home per diems. However, the managed care program being envisioned in Florida encourages the MCO to take their piece of profit off the top, even as the developed model leaves them fully exposed and at-risk. Managed Care for Florida's Medicaid beneficiaries can be a good thing, but for managed care to work there must be an upfront legislative commitment toward fully funding programs and services. Only then will Medicaid beneficiaries benefit by having allied health professionals from MCOs directing client care. We urge this committee to take a hard look at the long-standing Kaiser Permanente models of managed care. Kaiser is a stellar example of a successful MCO where quality drives the care.

Thank you.

Frequently Asked Questions

Q: Which assets can Medicaid require to be spent down before I can become eligible?

A: Assets such as savings and checking accounts, bonds, stocks, cash value in life insurance policies, real property, etc. With proper planning and advice, all of these assets can be preserved.

Q: If I am already in a nursing home can I still preserve my assets?

A: Yes. It is possible to protect most or all of your life savings and still be eligible for Medicaid within one month's time.

Q: If I have a spouse who still lives at home, are my spouse's income and assets counted by Medicaid?

A: The well spouse's income is not considered in determining the applicant's eligibility. However, all marital assets are considered regardless of how they are titled (joint or individual account).

Q: Why is this planning so important?

A: The money saved from years of hard work can be depleted quickly when a family member requires long-term care. The loss of lifetime savings can have a devastating financial and emotional impact on the whole family. With competent advice it's possible to preserve all of your life savings, your family home and investments and still qualify for Medicaid.

"Medicaid Information Resource was a big help when we put Mom into the nursing home. We made changes to her holdings and then applied for Medicaid. Mom was approved just as we hoped, and we were able to preserve all of her assets!"

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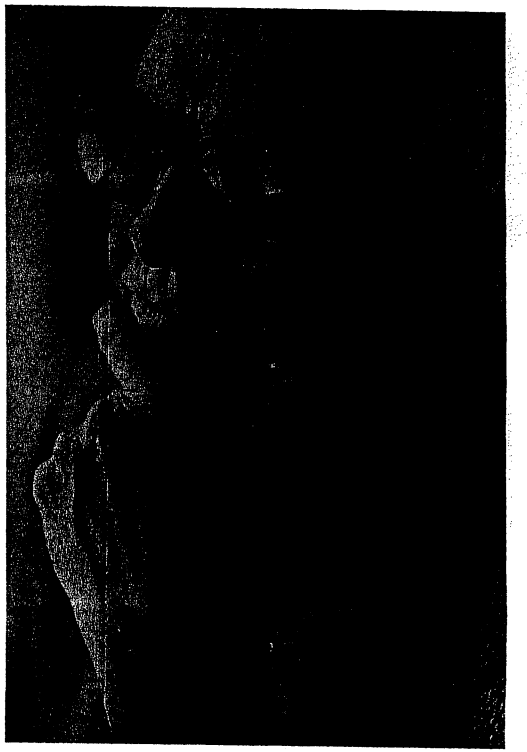

YOU'VE WORKED HARD
...FOR WHAT YOU HAVE
WE WORK HARD
...TO HELP YOU KEEP IT

February 2005 Newsletter

Happy Valentine's Day from Medicaid Information Resource!

This newsletter addresses how to properly structure and fund an Irrevocable Income Trust for a single person (or a widow or widower). Keep in mind that each person's situation is different and there is no "one correct way" to fund the Income Trust. However, if you follow these simple guidelines, the applicant will not have a problem passing the income test for Medicaid approval. We encourage you to provide this helpful guide to family members of applicants whose income exceeds the $1737 income limit (2005).

How to Properly Fund an Irrevocable Income Trust

Who Needs an Irrevocable Income Trust?
All Medicaid Institutional Care Program (ICP) applicants whose total combined monthly "Gross" income exceeds the state allowance of $1,737.00. Even if the applicant's "Gross" income is over the limit by one penny, the Income Trust is required for the applicant to qualify for Medicaid ICP.

What is an Irrevocable Income Trust? *(See the example on the other side of this newsletter)*
It is also known by other names such as Income Trust, Qualified Income Trust, Medicaid Income Trust or Miller Trust. It is a checking account that is opened using a trust document that provides legal "permission" to open a bank account in the name of the trust. The amount that is deposited to the trust checking account each month from the applicant's personal checking account is subtracted from the "Gross" income calculation. Transferring income to the trust account lowers the applicant's countable income so that it is less than the $1,737.00 monthly limit. There are two parts to the "Income Trust"

1) A properly drafted legal document usually prepared by an attorney. Once drafted, the document needs to be signed before a notary public. Once signed, this document is now a legal trust.
2) A new checking account is opened in the name of the Medicaid applicant titled: "John Doe Irrevocable Income Trust Account". This account will need to receive income deposits each month, as outlined in detail on the back of this newsletter.

What is "Gross" Income? This is the entire amount of income the applicant receives from the pension provider or Social Security BEFORE ANY DEDUCTIONS ARE TAKEN OUT. Also included in the gross income calculation are dividends and interest income from investments, rental property income, long-term health care checks, unemployment checks, disability checks, etc.)

What is Patient Responsibility? When a single person submits an application to the Florida Department of Children & Families (DCF) for Medicaid, he/she is required to contribute their gross monthly income to the nursing facility each month as their contribution to the cost of their care. This is referred to as "*Patient Responsibility*". The Medicaid applicant who is single is allowed two deductions: a $35 "*Personal Needs Allowance*" and a deduction for monthly private health insurance premium costs. To calculate Patient Responsibility, add up the gross income from all sources; then subtract $35; then subtract the cost of private health insurance premiums and the remainder is the applicant's *Patient Responsibility*.

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Bill Ruffing
Medicaid Planning Consultant
Certified Senior Advisor (CSA)

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March 14, 2005

The Cathedral Foundation

Good Afternoon.

I am Theresa Bertram, Chief Executive Officer of the Cathedral Foundation, located in Jacksonville, Florida.

Thank you for the opportunity to present testimony to this panel considering one of the most important matters facing the State of Florida. Your thoughtful leadership has been called upon to address the dynamic tension between limited resources and the increasing need for services.

I am here today representing the Cathedral Foundation, a nonprofit organization that provides services, housing and nursing home care for thousands of elders each day throughout Duval County. The Foundation has a long tradition of combining public, private and philanthropic resources to respond to elders and their families in their time of need. We raise hundreds of thousands of dollars each year to fund much needed services in the community and to makeup the difference between the Medicaid reimbursements and actual cost of care in our nursing home. These efforts have totaled millions of dollars over the years, yet, the value of our efforts is immeasurable in many ways.

Our services are often magnified by the involvement of volunteers. Nearly one-half of the over one thousand hot, nutritious meals delivered to people in their homes today were delivered by volunteers. Our auxiliary volunteers have been involved in the lives our nursing home residents since the day we opened twenty years ago. These selfless volunteers make a tremendous difference. Next month, we will be hosting our twentieth annual Volunteer Salute recognizing literally thousands of volunteers over the years and thousands upon thousands of volunteer hours invested in the quality of life for elders in our community.

Today, the State of Florida and its leadership are looking at the privatization of elder care. The strategy is touted as providing more flexible solutions for elders while limiting the financial exposure of the State. It is easy to understand why this strategy is appealing. In fact, it appears to offer solutions for elders and limit Medicaid spending.

There is another point of view. Proceeding with the privatization of elder care is equivalent to the 'fleecing of Florida.'

- Most participating managed care organizations are corporations in business to return a profit to its owners and shareholders. And, they are making what has been characterized as substantial profits. In my opinion, these profits are unacceptable. Elder care resources are precious resources that should be used for elder care and whenever possible, expanded by other resources and the involvement of volunteers. They should not be distributed as a return to shareholders.

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- To ease the concerns of legislators, community leaders and nonprofits themselves, managed care organizations are entering contracts with nonprofit providers to build the required networks as they enter a market. However, for the most part, they are not utilizing the nonprofit networks for services. In fact, the Cathedral Foundation's Community Services Division, the largest elder care provider in Duval County, has recently exited a contract with the largest managed care provider in the State of Florida. After a year without any referrals, we sent notice of our intent to exit the contract and in the same week, received a referral.

- Funding for elder care programs and adequate reimbursements for nursing home care are the sources of funding for managed care. This strategy will eventually unravel the nonprofit networks and continue placing our best nursing home providers at risk of closure.

- Donors and volunteers are marginalized in this strategy costing untold millions of dollars and divesting thousands upon thousands of hours spent in relationships with elders.

In closing, this panel is charged with recommending solutions that address the tension between the need for services and the increasing demand on limited resources. I believe managed care is a short-term solution that may be attractive to some constituencies today. However, over time, for-profit managed care will diminish resources available for elder care, erode the nonprofit network, marginalize the involvement of volunteers, eliminate the generosity of donors and ultimately, frustrate and disappoint elders, their families and the citizenry of Florida.

Thank you for your consideration of these views.

Theresa M. Bertram
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March 13, 2005

Comments – Select Committee on Medicaid Reform – Jacksonville

Workforce Issues:

- In order for Medicaid to reduce the costs associated with its most expensive and chronic enrollees, it must find new strategies aimed at improving the ability of non licensed caregivers to deliver high quality care to Medicaid eligible individuals in non institutional care settings like those found at home, in licensed adult family care homes and assisted living facilities. The national crisis in the availability of trained non licensed caregivers will undoubtedly impact on Florida's ability to accomplish its goals of reducing costs and providing quality community based care in that there is a lack of an adequately trained workforce prepared to take on more complex needs in the community and Florida has no mechanism by which to transfer best practices into the hands of frontline caregivers and to monitor state progress in the development of this work force.

  Proposed Solution: The legislature has pending before it ***SB 884*** and ***HB 161*** which calls for the creation of the Florida Caregiver Institute, Inc. This public not for profit would be housed at the University of South Florida Policy Exchange Center on Aging and would help create a framework by which lawmakers and others may begin the important work of transferring best practice techniques into the hands of frontline caregivers and developing policies that would lend assistance in the development of this component of the health care work force.

Assisted Living Facilities and Behavioral Health

- Florida has 760 state licensed limited mental health assisted living facilities that serve over 9000 adults with serious mental illnesses. Over 80% of these residents have a diagnosis of schizophrenia. These consumers are some of the most service intensive individuals in the state as a subgroup.

- The liability insurance rates have increased 25% over the last year for these facility with no increase in state funding since 2001. These facilities care for some of the most complex adults in the system at a rate of $27/day.

- The new minimum wage laws will place increased pressure on increasing wages and the new Medicaid reforms that affect the availability of access to community based behavioral health care could trigger displacement for some of the more complex individuals that depend on these settings for housing, food, supervision and assistance.

- Last year in Northeast Florida the state Medicaid program spent $2.7 million on individuals transitioning from state funded ALF care to nursing home care. Last year in this area of the state the Medicaid program spent almost $1.2 million per month on out patient behavioral health care with community mental health centers for residents of limited mental health assisted living facilities.

- The emerging medical needs of adults under the age of 60 with a diagnosis of schizophrenia is one of the fastest growing problems facing policy makers in the months ahead. As individuals become more medically complex, unlike residents of elder care ALFs who can age in place via the Medicaid waiver these residents must be relocated to a skilled nursing home prematurely because there is no other appropriate setting that can meet their needs.

- The new pre paid mental health plan that is being rolled out to control behavioral health costs has many flaws associated with its development and offers little to no choice for the consumers of these facilities. In the event that this managed care model fails to ensure access to care many of the most difficult to serve individuals will be forced to relocate in that many facilities will be unable to meet the needs absent the community based supports. This displacement poses huge public safety and overall health policy concerns for local officials.

Proposed Solution: The legislature has before it a bill ***SB 1852*** and ***HB 1535*** that will allow AHCA to pursue an alternative to the prepaid mental health plan as a demonstration project and permits the AHCA to amend a current Medicaid waiver so as to allow the state to ensure that those individuals with emerging medical needs can remain in place and receive the support they need in order to avoid a premature nursing home placement.

Closing Comments:

" *No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.*"

- United States Constitution – 14th amendment

Douglas D. Adkins
Executive Director
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ST. VINCENT'S

Mary Alice Phelan
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St. Vincent's Health System provides care through our 518-bed tertiary care medical center, our 238-bed skilled nursing facility, St. Catherine Laboure Manor, and ancillary services.

Medicaid provides a vital safety net meeting the needs of the poorest and most vulnerable persons of the state. Medicaid assists the needs of poor and vulnerable from birth through their eldest days. St. Vincent's is dedicated to be belief that healthcare is a basic human right and we continue to support the Medicaid program.

At present, the Medicaid system provides services based on a fee-for-service model. This gives the user a variety of services from which to choose. The proposed changes in Medicaid would take the choice from the consumer and direct it to a faceless network. The network would have the power to accept or decline the member's request for care, either medical or long-term.

As proposed by Governor Bush, the Managed Care Organization would contract with hospitals and other health care providers most likely offer rates even less that the current rates. Here at St. Vincent's our reimbursement for the hospital costs is 17% below our cost of providing service. For our skilled nursing facility, St. Catherine Laboure Manor, the reimbursement is almost thirty dollars a day less than our costs. In both cases, the difference is made up through cost shifting. But even this accounting devise has a limited life.

Since the MCO component is likely to be an investor-owned entity which must answer to stockholders, the services of the company will not come cheaply. With limited dollars, the savings will likely come from curtailment of services and steep cuts in reimbursement rates.

Florida does not have a good track record with Medicaid HMOs market longevity. In Duval County alone there have been ten Medicaid Managed Care Organizations, none of which is currently in existence. What happens to the lives of the insured when the CMO decides to leave the state, as have most others in the past?

Further, the proposal does not address a required level of coverage for children or adults. It apparently will be up to the managed care plan to devise its own level of coverage. We are concerned that without a required level of coverage, beneficiaries may find themselves without adequate care. What happens to the chronically ill who require a large measure of the healthcare resources. Will this group continue to receive the care they have received in the past?

In conclusion, St. Vincent's asks that any plan to reform Medicaid that is forthcoming contains the following provisions:

1. **Recognition of the basic dignity of each person.**

2. **The right to choose provider and place of care.**
   The place of care should be geographically desirable for the user.

3. **Basic levels of care should be determined and required for all levels, children through the frail elderly.**

4. **Care should be available at the appropriate level.**

5. **The Medically Needy provisions should be retained.**

5

The Florida Legislature
Senate Select Committee on Medicaid Reform
House Select Committee on Medicaid Modernization
Public Hearing Comment Form

Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately $14.4 billion (24% of the entire state budget) and are projected to more than double to $36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review. If you wish to mail this form or email your comments, please send to:

Senate Committee on Health Care
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100
e-mail: Medicaid.Reform@flsenate.gov

Name: Mike Ranze

Association: National Alliance for the Mentally Ill / Jacksonville

Address: 1251 Glengary Rd.
Jacksonville, Fla 32207

(Please use the front and back of this sheet to provide your information.)

I recommend that some of the reforms
Needed in the Medicaid System are:
1) ~~Fraction~~ Correct Current Problems
1. System has grown with little pre-planning
since Reagan and System and is driven by the Providers
of Service, Not the people receiving Services

2. Once You get in the system (most through disability) there are very few avenues out, i.e. You become reimbursable, Care is mostly Maintenance, Not recovery oriented + little data is collected on relationship of services to positive client outcomes. (That is kind of like paying for someone to work on your car even though they can't fix it)

3: Currently Quality assurance (what little is done) is primarily done on the record, Not the Consumer, (ie Medicaid audits agencies 2 to 3 years after the service is provided).

* Answer — There are innovations programs like Self directed Care, Redesignment, Peer Advocates, Medicaid + Aging + Adult Cash + Carry in which The Patient excels with Management of Services by Grant by developing + costing out a plan that is costed out + audited financially + clinically That is recovery oriented.

Thank You

Michael Connor

Florida's Medicaid Modernization Plan

Today's Medicaid (Source: Governor's Task Force Presentation)	Florida's New Medicaid (Source: Governor's Task Force Presentation)	Translation (Source: Northeast Florida Aging Advocacy Group)
Government as Consumer	Patients as Consumer	HMO as Consumer
Complex Programs	Consistent Policies	One size fits all?
Government Controls	More Consumer Choice	HMO Controls
Centralized Planning/Purchasing	Marketplace decision-making	Profit-driven Healthcare Decision-making
Blank Check	Defined Investment	Capped Coverage/Benefits
Unsustainable Growth	Predictable Growth	Blockgrant

Translation

- HMO as Consumer
  - HMOs make the decisions
  - HMOs are not in 35 counties presently. How will patients in those counties purchase services?
  - Multiple plans will be offered (3 different sizes). How does the patient choose?
  - Is this consistent or complex?
- One Size Fits All
  - When the services offered in EACH of the three plans are needed, then how does one choose?
  - How does one get all they need if they can only choose one?
- HMO Controls
  - What choices will patients have in those areas where there is not an HMO?
  - Entitlements will be gone. Some people may get more services, but others will get less or none at all.
- Profit-driven Healthcare Decision-making
  - Moving from a not-for-profit network to a for-profit network.
  - Moving from client/patient oriented decision making to financial oriented decision making.
- Capped Coverage/Benefits
  - Sliding fee scale.
  - Entitlement gone.
  - Those who could afford more could purchase more.
  - Some will go without.
  - Cost shifting to local entities (e.g. hospitals, local health departments, etc.).
- Blockgrant
  - Fixed dollars – not predictable growth.
  - Same funding despite population growth.
  - Does not take into account healthcare cost increases.
  - More people moving to Florida, more people aging, more people with disabilities, more uninsured, but no more funding.
  - Funds will not match growth – will not meet the need.
  - Unsustainable Need.

Suggestion/Recommendations

- If the Governor's Plan is going to be *the* plan for modernizing Florida's Medicaid Program:
  - Consumers and general public must be made aware of prior history where Medicare HMOs were not turning a profit, withdrew from the market and left the elderly without coverage.
  - To keep this from happening again, safeguards must be in place that:
    - Support the existing service delivery structure for services to elders
    - Address quality assurance, monitoring and patient outcomes
    - Include Due Process and provide for Fair Hearings

- Medicaid's growth is being attributed to long term care costs for the elderly and disabled (estimated 80% of Medicaid Budget). Since the intent of Medicare was to address this, our final recommendation is to move the long term care costs to Medicare, which will free up the Medicaid funding for the other programs and services.

6

The Florida Legislature
Senate Select Committee on Medicaid Reform
House Select Committee on Medicaid Modernization
Public Hearing Comment Form

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Name: Joshua Copper

Association: Pro Med Claims

Address: 55100 Hive lane

Callahan FL, 32011

(Please use the front and back of this sheet to provide your information.)

As a billing representative serving 30 individuals and groups consisting of various therapist we are very concerned with a switch to HMO states. Therapists have an extremely difficult time getting in network because insurance companies do not

credential therapists, their network is not open or individual providers are not allowed in network. Among the providers we represent the average medicaid case load is 76%. If something is not done to force these HMOs to allow therapists to become in network we expect slightly more than half of our providers to become unemployed.

We also think that the committe should take an extra hard look at the early intervention program and allow the benefits supplied to delayed children under the HMOs. Lack of normal physiological development and delays in speech development can greatly reduce the development and quality of life of children, and can easily bleed over into adulthood.

7

The Florida Legislature
Senate Select Committee on Medicaid Reform
House Select Committee on Medicaid Modernization
Public Hearing Comment Form

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530 Knott Building
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(*Please use the front and back of this sheet to provide your information.*)

How Federalism Could Spur Bipartisan Action On The Uninsured

A way to end the political impasse and make progress on covering uninsured Americans.

by Henry J. Aaron and Stuart M. Butler

ABSTRACT: National efforts to greatly reduce the number of uninsured Americans have made little progress for decades because achieving majority support for any one approach has proved to be impossible. While as authors we remain unreconciled on the best solution, we share the belief that federally supported state experimentation is a promising way to make progress. States should be allowed to try widely differing solutions with federal financial support under legislated guidelines, including specific protections and measurable goals. Congress would enact a "policy toolbox" of federal initiatives that states could include, and funding to states would be linked to success in reaching the goals.

NEARLY EVERYONE THINKS that something should be done to reduce the number of Americans lacking health insurance. Unfortunately, while numerous plans exist on how to reach that goal, few agree on any one. Indeed, as authors we disagree on how best to extend and assure health insurance coverage. Nonetheless, we believe that using the pluralism and creative power of federalism is the best way to break the political logjam and to discover the best way to expand coverage.

Accordingly, we believe that states should be strongly encouraged to try any of a wide range of approaches to increasing health insurance coverage and rewarded for their success. This approach offers both a way to improve knowledge about how to reform health care and a practical way to initiate a process of reform. Such a pluralist approach respects the real, abiding differences in politics, preferences, traditions, and institutions across the nation. It also implies a willingness to accept differences over an extended period in order to make progress. And it recognizes that permitting wide diversity can foster consensus by revealing the strengths and exposing the weaknesses of rival approaches.

Despite our abiding disagreements on which substantive approach to extend-

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W4-168 31 March 2004
DOI 10.1377/hlthaff.W4.168

ing coverage is best, we believe that people of goodwill must be prepared to countenance the testing of ideas they oppose if progress is to be made. Moreover, we believe that there is no hope for legislation to begin to transform the largest U.S. industry—health care—unless such legislation enjoys strong support from both major political parties.

Using Federalism To Spur Action

Proposals to reduce the number of uninsured Americans abound. Some favor expanding government programs, such as Medicaid. Others favor refundable tax credits to help families buy private health insurance. Still others favor regulatory approaches, such as changes in insurance rules. But working together in health care to achieve a goal shared by virtually everyone has proved to be impossible. One reason for this is that the capacity to reach substantive compromise in Washington has seriously eroded.[1] Among the causes is the widespread view that reforming the complex health care system requires very carefully designed and internally consistent actions. Some say that it is like building a new airplane: Unless all the key parts are there and fit together perfectly, the airplane will not fly. Thus, many proponents of particular approaches fear that abandoning key components of their proposals to achieve a compromise will prevent a fair test of their favored approach and lead to failure. Another obstacle is that many lawmakers believe that approaches that might conceivably work in one part of the country, given the cultural, philosophical, or health industry conditions prevailing there, will not work in their state or district because of different local conditions. This view leads many in Congress to resist proposals that might work in some areas because they believe that those proposals could make things worse for their constituents.

These and other factors have stalled efforts to extend health insurance and achieve other reforms for decades. The enactment of Medicare and Medicaid stands as one notable—and instructive—exception to that pattern. Medicare sprang from comprehensive social insurance initiatives of congressional Democrats, Medicaid from limited needs-based approaches of congressional Republicans. The passage of each program was possible only because the two initiatives were linked in the form of a trade-off, not so much by blending some elements of each approach but by moving forward with two programs in parallel: Medicare for the elderly and disabled, and Medicaid for the poor of all ages. That experience illustrates a principle of politics: that progress often requires combining elements of competing proposals into a hybrid legislative initiative, in which internally consistent approaches operate in parallel.

In our view, federalism offers a promising approach to the challenge of building support to tackle the problem of uninsurance. While proponents of nationwide measures to introduce health insurance tax credits, or to extend Medicare or the State Children's Health Insurance Program (SCHIP) to other groups, should of course continue to make their case for national policies, we emphasize an initia-

"All advocates of health insurance reform, like residents of Lake Wobegon, seem to believe that their plans are above average."

tive designed to support states in launching a variety of localized initiatives. Under this process, the federal government would reward states that agreed to test comprehensive and internally consistent strategies that succeeded in extending coverage within their borders. In contrast to block grants, federal-state covenants would operate within congressionally specified policy constraints designed to achieve national goals for extending health insurance. These covenants would include plans ranging from heavy government regulation to almost none, as long as the plans were consistent with the broad goals and included specified protections. States could also select items from a federally designed "policy toolbox" to include in their proposals. Allowable state plans would include forms of single-payer plans, employer mandates, mandatory individual purchase of privately offered insurance, tax credits, and creative new approaches. States would be free not to undertake such experiments and continue with the current array of programs, but sizable financial incentives would be offered to those that chose to experiment and financial rewards given to those that achieve agreed-upon goals.

The model we propose builds upon proposals we have outlined elsewhere.[2] It is also compatible with some other federalism approaches, such as the plan advanced by the Institute of Medicine.[3] We favor a wide diversity of federal-state initiatives for three reasons. First, fostering a bold program in a state will produce much information that will aid the policy discovery process. Successes will encourage others to follow, while unanticipated problems will force redesign or abandonment and will be geographically contained. Second, encouraging bold state action will quickly and directly extend coverage to many of the uninsured. Instead of facing continued national inaction or the potential for disruption of state initiatives by future federal action, states would have the incentive and freedom to act decisively. Third, we see no evidence of an emerging consensus on how to deal with these problems at the national level. But our proposal is based on the observation that advocates of rival plans trust their preferred approaches enough to believe that a real-life version would persuade opponents and create a consensus. Not all can be right, of course, but all advocates of health insurance reform, like residents of Lake Wobegon, seem to believe that their plans are above average. Thus, they should be open to the idea of testing diverse proposals. Our proposal is a process to enable policymakers to discover which is right, either for the whole country or for a region.

Core Elements

We propose that Congress provide financial assistance and a legal framework to trigger a diverse set of federal-state initiatives. To help break the impasse in

Congress over most national approaches, we propose steps designed to enable "first choice" political ideas to be tried in limited areas, with the support of states and through the enactment of a federal "policy toolbox" of legislated approaches that would be available to states but not imposed on them. Our view is that elected officials would be prepared to authorize some approaches now bottled up in Congress if they knew that the approach would not be imposed on their states. Our proposed strategy would contain six key elements.

■ **Goals and protections.** First, Congress would set certain goals and general protections. Goals would be established for extending coverage, and perhaps improving the coverage of some of those with inadequate coverage today. One such goal could be a percentage reduction in the number of uninsured people in a state. The more precise the goals, the more contentious they are likely to be. But clear and measurable goals under the proposed covenants are necessary if the system of financial rewards described below is to work effectively.

What is "insurance"? For a coverage goal to mean anything, it would have to define what constitutes "insurance." Specifying adequate coverage in health care is no easier than quantifying an adequate high school education, and when money follows success, drafting such definitions becomes even more difficult.

In defining what is meant by *adequate insurance*, agreement on two characteristics is vital: the services to be covered and the maximum residual costs (deductibles and copayments) that the insured must bear. States could be more generous than these standards. Instead of speciying precisely what states must do in each of these dimensions, we suggest that Congress establish a required actuarial minimum—such as the cost of providing the benefit package of the Federal Employees Health Benefits Program (FEHBP) for the state's population—as the standard, with states retaining considerable latitude on which services to include and how much cost sharing to require. Whether to set this actuarial standard high or low will be controversial and will determine the overall cost to the federal government of eliciting state participation.

Both high and low benefit standards suffer from well-known problems. High standards would raise program costs and weaken individuals' incentives to be prudent purchasers of health care. Low standards expose patients to sizable financial risk and raise questions about whether to restrict patients' right to buy supplemental coverage. Thus, federal legislation would not specify the content of insurance plans beyond some such actuarial amount. States would then be free to design plans as they wish, although certain types of plans might be presumptively acceptable (see below), and others could be negotiated as part of a covenant. The exact mix of benefits could vary within reason, but no further limits would be imposed. One goal of this approach, after all, is to encourage experimentation to generate information on whether particular configurations of benefits work better than others. It might turn out, for example, that states would adopt quite different plans with similar actuarial values. One group might opt for high-deductible plans

covering a wide range of services with no cost sharing above the deductible and generous relief from the deductible for the poor, while others might adopt a system with low deductibles and modest cost sharing but covering a much narrower range of benefits. Discovering how individuals' and providers' attitudes and behavior differ under such plans and how health outcomes vary would provide valuable information for private health insurance planners and government officials.

Protections for individuals. In addition to the definitional question, the question also arises, What limitations and protections should be applied to state experiments? If a simple net reduction in uninsurance guaranteed a financial reward to a state, for example, the state would have the incentive to drop coverage of costly high-risk adults and extend coverage to less costly (healthier and younger) workers. Some such concerns could be addressed in negotiating covenants, but some broad protections and policy "corridors" would be established under our proposal and would be necessary to achieve political support.

One of the most politically sensitive would be a *primum non nocere* limitation. That is, states could not introduce a plan that reduced coverage for currently insured populations, most notably the Medicaid population, beyond some minimum amount. We believe that no reform proposal is likely to be achievable without that restriction. Most Medicaid outlays in many states are not strictly mandated by federal law, in the sense that some beneficiaries and some services for all beneficiaries are optional. States provide optional coverage because federal law permits it, and the federal match makes its provision attractive to states. If incentives were introduced to cover the non-Medicaid population, states might find it financially and politically attractive to increase the total number of insured people by curtailing Medicaid eligibility and benefits and using the money saved, together with federal support, to cover a larger number of people who are uninsured but less poor.

Designing and enforcing rules to prohibit or limit such "insurance swapping" would be extremely challenging but politically—and, one could argue, morally—essential. On the other hand, we believe that states should have some opportunity to propose different ways of delivering the Medicaid commitment to the currently insured population, as long as the degree and quality of coverage were not diminished. That form of Medicaid protection could stimulate creativity and improvement in coverage for the poorest citizens while avoiding any threat to their existing coverage. To be sure, there are disagreements, including between us, on the degree of freedom states should have in deciding how to deliver the Medicaid commitment. Positions range from only minor tweaking to sweeping changes in the delivery system, such as allowing states to use Medicaid money to subsidize individual enrollment in an equivalent private plan. The degree of flexibility states should have, while maintaining eligibility and level of coverage, is a difficult political issue for Congress to decide.

Acceptable state proposals would also have to limit cost sharing and features

analogous to pension nondiscrimination rules. We believe that requirements, consistent with the general goals and protections we propose, are needed to ensure that lower-income households do not face unaffordable coverage. Without such limits, states could reduce the number of uninsured people and secure attendant federal financial support, for example, by instituting an individual mandate with a high premium that would effectively make insurance universal among the financially secure and do little for the poor. States would need to propose a fair, plausible way of meeting the requirement, such as by mandating some form of community rating or through a cross-subsidy to more vulnerable populations.

The federal government should establish broad guidelines, but no more. A key principle of our proposal is that state officials are more likely than federal officials to design successful solutions to those problems that members of the policy or congressional staff community have failed to solve. Congress can and should set the parameters, but it should avoid micromanagement.

■ **"Policy toolbox" of federal policies and programs.** A feature of the congressional impasse noted earlier is that many plausible health initiatives that might merit testing, and have support in some states, are blocked by other lawmakers who oppose the introduction of the approach in their own state or across the country. Thus, we propose that Congress enact presumptively legitimate approaches to the expansion of health insurance coverage as a "policy toolbox" that would be available to states à la carte to apply within their borders. Lawmakers could safely vote to permit an initiative, confident that it would not be imposed on their states. In this way, potentially useful policies and programs could be "unlocked" from Congress and become available for states to use in their own initiatives.

A policy toolbox likely would include expansions of existing policies, such as raising income limits under Medicaid or lowering the age of Medicare eligibility. It could include arrangements to subsidize individual buy-ins to the FEHBP, refundable tax credits or their equivalent (perhaps with some steps to modify the federal income tax exclusion for employer-sponsored health insurance costs), mandating employer or individual coverage, or creating a single state insurance plan though which everyone may buy subsidized coverage.

Other possible examples might include the following: (1) Remove regulatory and tax obstacles to churches, unions, and other organizations providing group health insurance plans. This could open up new forms of group coverage offered though organizations with an established membership and common values. (2) Allow Medicaid and SCHIP to cover additional populations, with greatly enhanced federal matching payments, and perhaps to operate in very different ways—with appropriate safeguards to protect those who are covered under current law. Both federal welfare legislation and SCHIP, for example, included safeguards to preserve existing Medicaid coverage. (3) Extend limited federal Employee Retirement Income Security Act (ERISA) protection to large corporate health plans willing to enroll nonemployees, and extend the tax exclusion to those

enrollees. This could lead in a state to expanded access to comprehensive coverage. (4) Provide a voucher to individuals designed to mimic a comprehensive refundable tax credit for health insurance. This could allow the practical issues of a major tax credit approach to be examined. (5) Enact legislation to make forms of FEHBP-style coverage available to broader populations within states. This would enable states and federal government to explore the issues associated with extending the program to nonfederal employees and retirees. (6) Enable states to establish association plans and other innovative health organizations.

We emphasize that any menu of tools would be optional for states. None would be required. Members of Congress would be more likely to agree to the inclusion of elements they would deplore in their own states if they knew that no state, including their own, would be forced to adopt them than they would be in a nationally uniform system. Some lawmakers, for instance, oppose association plans because they believe that such plans would disrupt successful state insurance arrangements. Under the menu approach, association plans would be introduced only in states wishing to use them as part of their overall strategy.

■ **State proposals, federal approval.** Under our proposed strategy, states interested in a bold, creative initiative would design a proposal consistent with the goals and restrictions established by Congress. Typically this proposal would include some elements from the federal policy toolbox in conjunction with state initiatives.

Needless to say, a critical congressional decision would concern mechanisms for approving state plans and monitoring state performance. States would no doubt seek to take advantage of every financial opportunity to game the system and to stretch agreements to the limit, as the almost zany history of the Medicaid upper payment level (UPL) controversy makes painfully clear. Yet monitoring state behavior, determining state violations, and enforcing penalties on states is enormously difficult. Moreover, the entity could (and we think should) have the power to negotiate parts of a proposal, not merely approve or reject it, so that refinements could be made consistent with Congress's objectives.

But what entity should this be? It might seem natural to designate an executive agency that reports to the president, such as the Department of Health and Human Services (HHS). We suspect, however, that many members of Congress would refuse to cede so much selection authority to another branch of government and that roughly half would fear partisan decisions by an administration of the "other" party. Congress would likely insist on adding suffocating selection criteria and other restrictions to executive-department decisions, jeopardizing the very creativity we intend. Thus, we favor instead an existing or newly created body that has independence but ultimately answers to Congress. A new bipartisan body might perform this function with members selected by Congress and the administration or with members also representing the states, with technical advice from the U.S. General Accounting Office (GAO). This body would evaluate and negotiate draft state proposals according to the general requirements speci-

fied by Congress and then present a recommended "slate" of proposals to Congress for an up-or-down vote without amendment. Once the state proposals had been selected, HHS would be responsible for implementing the program.

Bipartisan willingness to authorize state programs and to appropriate sufficient funds to elicit state participation also requires that members of Congress believe that approaches they find congenial will receive a fair trial and agree that approaches they reject will also receive a fair trial. Unfortunately, current federal legislation makes two key approaches difficult to implement in individual states or even groups of states: a single-payer plan and an individual mandate combined with refundable tax credits. A federalist approach should include mechanisms that would enable states to give such proposals as fair and complete a test as possible, both because that would provide valuable information and because the political support of their advocates is important in Congress.

Crafting a single-payer experiment. ERISA, which exempts self-insured plans from state regulation, is the primary technical obstacle to testing single-payer plans. The political sensitivity to modifications in ERISA is difficult to exaggerate. Any attempt to carve out an exception from ERISA for state programs to extend coverage would probably doom federal legislation. But states could create "wrap-around" plans to cover all who are not currently insured, or even to cover all who are not insured under plans exempted by ERISA from state regulation. While such an arrangement would not be a single-payer plan, it could achieve universal coverage, which is one defining characteristic of single-payer plans, and arguably be sufficient for a valid test. After all, the U.S. health care system is characterized by different subsystems for certain populations and has a form of single-payer coverage for military veterans. But of course the real test is whether advocates of single-payer plans regard such a limited arrangement as a fair trial.

An individual tax credit approach. The obstacles to a state-level individual mandate with a refundable credit are also serious and complicated. We presume that an individual mandate would require some contribution from people with incomes above defined levels. Such a mandate raises both political and practical questions. Testing federal tax reform in selected geographic areas also raises constitutional and practical issues, although advocates of the approach maintain that other site-specific programs involving federal tax changes, such as enterprise zones, have passed muster. In addition, for a limited experiment it might be possible to design subsidy programs that would mimic tax relief.

Administering a refundable tax credit would pose formidable difficulties for some states, particularly those that do not have a personal income tax. In all states, the logistics of providing a credit with reasonable accuracy on a timely basis would be challenging. So, too, would deciding how to address such administrative problems as households that live in one state yet work in another. Advocates for tax credits say they have solutions to these and similar challenges, just as supporters of single-payer approaches or employer mandates claim to have answers to

challenges facing those approaches. For instance, some maintain that the employment-based tax withholding system could serve as a vehicle for refundable credits or equivalent subsidies and would make individual enrollment practical.[4] Whether or not they are right is of course disputed by their critics. The beauty of a "put up or shut up" federalism initiative is that it offers a chance for advocates to offer such solutions in practice instead of in theory.

Using "managed federalism" to build support? Deciding how many states could qualify for experiments is an open political and technical question. One approach would be to limit it to a few states. This would limit costs but has little else to be said for it. Accordingly, we would favor opening the program to all states wishing to accept a federal offer. Nevertheless, we recognize that some lawmakers would be reluctant to vote for a process of federal-state innovation unless they were sure that certain "generic" or "standard" approaches were included—especially if the number of states in the program were to be limited. In particular, we believe that our proposal can win congressional support only if liberals and conservatives alike are fully convinced that the approaches each holds dear will receive a fair and full trial in practice.

While we believe that any state initiative that meets approval should be welcomed, political considerations thus might require that no state's proposal would be approved unless a sufficient range of acceptable variants was proposed. For example, strong advocates of market-based or single-payer approaches might find the federalism option acceptable only if each was confident that favored approaches would be tested

■ **Adequate data collection.** To determine whether a state was actually making progress toward a goal, accurate and timely data would be needed. These data would include surveys of insurance coverage, with sufficient detail to provide state-level estimates. Such surveys would be essential to show whether the states were making progress in extending health insurance coverage. They are vital to the success of the whole approach because payments to states (apart from modest planning assistance) should be based on actual progress in extending coverage, not on compliance with procedural milestones.

Congress should also assure that states report on use of health services, costs, health status, and any other information deemed necessary to judge the relative success of various approaches to extending coverage. Only a national effort could ensure that data are comparable across states. States' cooperation with data collection would be one element of the determination of whether a state was in compliance with its covenant and was therefore eligible for full incentive payments. The experience with state waivers under welfare before enactment of the 1996 welfare reform clearly illustrates the power and importance of such data collection. The cumulative effect of the reports showing the effectiveness of welfare-to-work requirements in reducing rolls, increasing earnings, and raising recipients' satisfaction transformed the political environment and made welfare reform

inescapable.

■ **Rewarding progress.** Congress would design a formula under which states would be rewarded for their progress in meeting the agreed federal-state goals of extending insurance coverage. As experience with countless grant programs attests, haggling over such formulas can become politics at its grubbiest, with elected officials voting solely on the basis of what a particular formula does for their districts. Even without political parochialism, designing a formula that rewards progress fairly is no easy task. For one thing, states will be starting from quite different places. The proportion of states' uninsured populations under age sixty-five during 1997–1999 ranged from 27.7 percent in New Mexico and 26.8 percent in Texas to 9.6 percent in Rhode Island and 10.5 percent in Minnesota and Hawaii.[5] Designing an incentive formula to reward progress amid such diverse conditions is both an analytical and a political challenge. Moreover, the per capita cost of health care varies across the nation, which further complicates the assessment of progress. The cost of extending coverage depends on the geographic location, income, and health status of the uninsured population. Having financial access may be hollow in communities where services are physically unavailable or highly limited. Extending coverage may require supply-side measures to supplement financial access.

We believe that the only way to design such a formula is to remove the detailed design decisions from congressional micromanagement. We suggest that Congress be asked to adopt the domestic equivalent of "fast-track" trade negotiation rules or base-closing legislation. Under this arrangement, Congress would designate a body appointed in equal numbers by the two parties, to design an incentive formula that Congress would agree to vote up or down, without amendments. Such a formula would have to recognize the different positions from which various states would start. Any acceptable formula would have to reward both absolute and relative reductions in the proportions of uninsured people. Whether financial incentives would be offered for other dimensions of performance and how performance would be measured constitute additional important challenges.

■ **Sources of funding.** Bleak budget prospects could cause one to give up on this or any other attempt to extend health insurance coverage broadly. But as recent history amply illustrates, the political and budgetary weather can change dramatically and with little notice. What funding approach would be desirable if funds were available? Under our proposal, the federal funding would be intended for several broad purposes: (1) A large portion of the money would be used to help states actually fund approaches to be tested. (2) Some funding (perhaps with assistance from private foundations) would provide national support and technical assistance to states. A model to consider for such support is the Health Resources and Services Administration (HRSA) State Planning Grants program, which both funds state planning activities and provides federal support and technical assistance. (3) Some funds would cover the cost of independent performance monitoring. (4) Some funds would be set aside to reward states for meeting the goals in their agreed-upon plan.

Congress might consider an automatic "performance bonus" system similar to the mechanism used in welfare reform. Congress could also consider withholding the periodic release of part of a state's grant pending a periodic assessment by the independent monitor of the degree to which the state is accomplishing the objectives specified in its covenant. Only those states willing to offer proposals designed to achieve the national goals would be eligible for a share of the funding or for the menu of federal policy tools. A state could decline to offer a proposal and remain under current programs.

FEDERALISM ENABLES THE STATES to undertake innovative approaches to challenges facing the United States. Federal legislation often grants states broad discretion in designing even those programs for which the federal government bears much or most of the cost. In health care as well as education or welfare, states have been the primary innovators. But the federal government limits, shapes, and facilitates such innovation through regulation, taxation, and grants. Such a partnership is bound to be marked by conflict and tension as state and federal interests diverge.

A creative federalism approach of the kind we propose would change the dynamics of discovering better ways to expand insurance coverage, just as a version of this approach triggered a radical change in the way states addressed welfare dependency. By actually testing competing approaches to reach common goals, rather than endlessly debating them, the United States is far more likely to find the solution to the perplexing and seemingly intractable problem of uninsurance.

An earlier version of this paper was presented at a conference convened by the Council on Health Care Economics and Policy, 19 September 2003, in Washington, D.C.

NOTES

1. P.S. Nivola, "Can the Government Be Serious?" in *Agenda for the Nation*, ed. H.J. Aaron, J.M. Lindsay, and P.S. Nivola (Washington: Brookings Institution, 2003), 485–452; and J.Q. Wilson, "Reflections on the Political Context," ibid., 527–549.
2. S.M. Butler, "Using Federalism to Spur Action on the Uninsured," Heritage Foundation Working Paper (Washington: Heritage Foundation, May 2003); H.J. Aaron and S.M. Butler, "How Federalism Could Spur Bipartisan Action on the Uninsured" (Paper presented to the Council on Health Care Economics and Policy conference, "Health Insurance Expansions 2004: Examining the Options," in Washington, D.C., September 2003); H.J. Aaron, "Template for Health Care Coverage," *Washington Post*, 25 November 2002; and H.J. Aaron and S.M. Butler, "Four Steps to Better Health Care," *Washington Post*, 6 July 2003.
3. J.M. Corrigan, A. Greiner, and S.M. Erickson, eds., *Fostering Rapid Advances in Health Care: Learning from System Demonstrations* (Washington: National Academies Press, 2002).
4. L. Etheredge, "How to Administer Health Insurance," Backgrounder no. 1516 (Washington: Heritage Foundation, 31 January 2002).
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Insuring America's Health: Principles and Recommendations

The Sixth and Final Report of the
Committee on the Consequences of Uninsurance
Of the Institute of Medicine of the National Academy of Sciences
January 2004

BOX 6.1
Vision, Principles, and Recommendations

Vision

The Committee on the Consequences of Uninsurance envisions an approach to health insurance that will promote better overall health for individuals, families, communities, and the nation by providing financial access for everyone to necessary, appropriate, and effective health services.

Principles

1. Health care coverage should be universal.
2. Health care coverage should be continuous.
3. Health care coverage should be affordable to individuals and families.
4. The health insurance strategy should be affordable and sustainable for society.
5. Health care coverage should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

Recommendations

The Committee recommends that these principles be used to assess the merits of current proposals and to design future strategies for extending coverage to everyone.

****

The Committee recommends that the President and Congress develop a strategy to achieve universal insurance coverage and establish a firm and explicit schedule to reach this goal by 2010.

****

The Committee recommends that until universal coverage takes effect, the federal and state governments provide resources sufficient for Medicaid and the State Children's Health Insurance Program to cover all persons currently eligible and prevent the erosion of outreach efforts, eligibility, enrollment, and coverage.

Insuring America's Health: Principles and Recommendations

The Sixth and Final Report of the
Committee on the Consequences of Uninsurance
Of the Institute of Medicine of the National Academy of Sciences
January 2004

Executive Summary

Abridged by Ken Frisof MD for Bridging Coalitions: Communities United for Universal Health Care

The lack of health insurance for tens of millions of Americans has serious negative consequences and economic costs not only for the uninsured themselves but also for their families, the communities they live in, and the whole country. The situation is dire and is expected to worsen.

In a series of five reports, the Committee concluded that:

- The number of uninsured individuals under the age of 65 is large, growing, and has persisted even during periods of strong economic growth.
- Uninsured children and adults do not receive the care they need; they suffer from poorer health and development, and are more likely to die early than are those with coverage.
- Even one uninsured person in a family can put the financial stability and health of the whole family at risk.
- A community's high uninsured rate can adversely affect the overall health status of the community, its health care institutions and providers, and the access of its residents to certain services.
- The estimated value across the population in healthy years of life gained by providing health insurance coverage is almost certainly greater than the additional costs of an "insured" level of services for those who now lack coverage.

Lessons from the Past and Present

Past campaigns have yielded both incremental changes and major reforms, but not universal coverage, due to the challenges to major structural changes posed by American political arrangements and the lack of political leadership strong and sustained enough to forge a workable consensus on coverage legislation. In addition, the opposition of provider, insurer and business groups with economic interests potentially adversely affected by specific reform proposals has blocked universal coverage even though many have agreed with the general need for reform.

Federal incremental reforms over the past twenty years have made little progress in reducing overall uninsured rates nationally, although public program expansions have improved coverage for targeted previously uninsured groups. Federal reforms of employment-based insurance have not included provisions for assuring affordability and, thus, have had limited effect.

Although some states have made significant progress in reducing uninsurance, even the states that have led major coverage reforms have large and persisting uninsured populations.

Conclusion: The persistence of uninsurance in the United States requires a national and coherent strategy aimed at covering the entire population. Federal leadership and federal dollars are necessary to eliminate uninsurance, although not necessarily federal administration or a uniform approach throughout the country. Universal health insurance coverage will only be achieved when the principle of universality is embodied in federal public policy.

Vision Statement and Principles

The Committee on the Consequences of Uninsurance envisions an approach to health insurance that will promote better overall health for individuals, families, communities and the nation by providing financial access to everyone to necessary, appropriate, and effective health services.

The evidence reviewed by the Committee in its first five reports contributes to this shared vision and the following five key principles:

1. Health care coverage should be universal
2. Health care coverage should be continuous.
3. Health care coverage should be affordable to individuals and families.
4. The health insurance strategy should be affordable and sustainable for society.
5. Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered and equitable.

Using the Principles and Next Steps

The Committee concludes that health insurance coverage for everyone in the United States requires major reform initiated as federal policy.

The Committee recommends that the President and Congress develop a strategy to achieve universal insurance coverage and to establish a firm and explicit schedule to reach this goal by 2010.

The Committee recommends that, until coverage takes effect, the federal and state governments provide resources sufficient for Medicaid and SCHIP to cover all persons currently eligible and prevent the erosion of outreach efforts, eligibility, enrollment and coverage.

It is time for our nation to extend coverage to everyone.

For more information, go to
http://www.iom.edu/uninsured.

HEALTH CARE FOR ALL

AN INTERNATIONAL TIMELINE

Year in which elected representatives enacted health care coverage for everyone:

Germany	1883
Switzerland	1911
New Zealand	1938
Belgium	1945
France	1945
United Kingdom	1946
Sweden	1947
USA	*~~1948~~**
Greece	1961
Japan	1961
Canada	1966
Denmark	1973
Australia	1974
Italy	1978
Portugal	1979
Spain	1986
USA	*~~1994~~**
South Africa	1996

* Proposed by the President. Strong public support for the principle. Failed in Congress.

If the other democracies of the world can assure health care for all their people, why can't we?

produced by the
Universal Health Care Action Network (UHCAN)
Tel: 800-634-4442

Email: seekingjustice@uhcan.org
Web Site: http://www.uhcan.org

Comparisons of International Health Systems

NHI = National Health Insurance **NHS = National Health Service**

	HEALTH SYSTEM CHARACTERISTICS			FINANCING				HEALTH CARE INDICATORS			
Country	Type of system	Ownership of health facilities	Physician choice	Per capita spending[1]	% GDP[2]	% public expenditures of total cost[3]	% of costs paid by patients out-of-pocket[4]	Life expectancy[5]	Infant mortality per 1,000 live births[6]	% population over 60[7]	# uninsured
USA	Pluralistic	Private	Limited by insurance plan	$4,178	14.2	47	21	77.0	8	16.2	43,000,000
Canada	NHI	Private	Free choice	$2,312	9.2	71.4	na	79.3	6	16.9	none
United Kingdom	NHS	Public	Free choice of PCP	$1,461	6.9	84.3	8	77.5	6	20.7	none
France	NHI	Private	Free choice	$2,077	9.6	80.7	14	79.3	5	20.5	none
Germany	NHI	Private	Free choice	$2,424	10.5	78.3	8	78.2	5.3	23.7	none
Sweden	NHS	Public	Free choice within county	$1,746	7.2	80.2	na	80.0	3.8[7.1]	22.7	none
Netherlands	NHI	Private	Free choice	$2,070	8.6	77	11	78.3	6[7.2]	18.4	none
Australia	Pluralistic	Public/ Private	Public: limited by hospital Private: free choice	$2,043	8.4	66.5	na	80.0	6[7.2]	16.5	none
Japan	NHI	Public/ Private	Free choice	$1,822	7.2	78.4	12	81.4	4.3	23.8	negligible

Note: All footnote references may be found on the reverse side of this page.

UNIVERSAL HEALTH CARE ACTION NETWORK (UHCAN)
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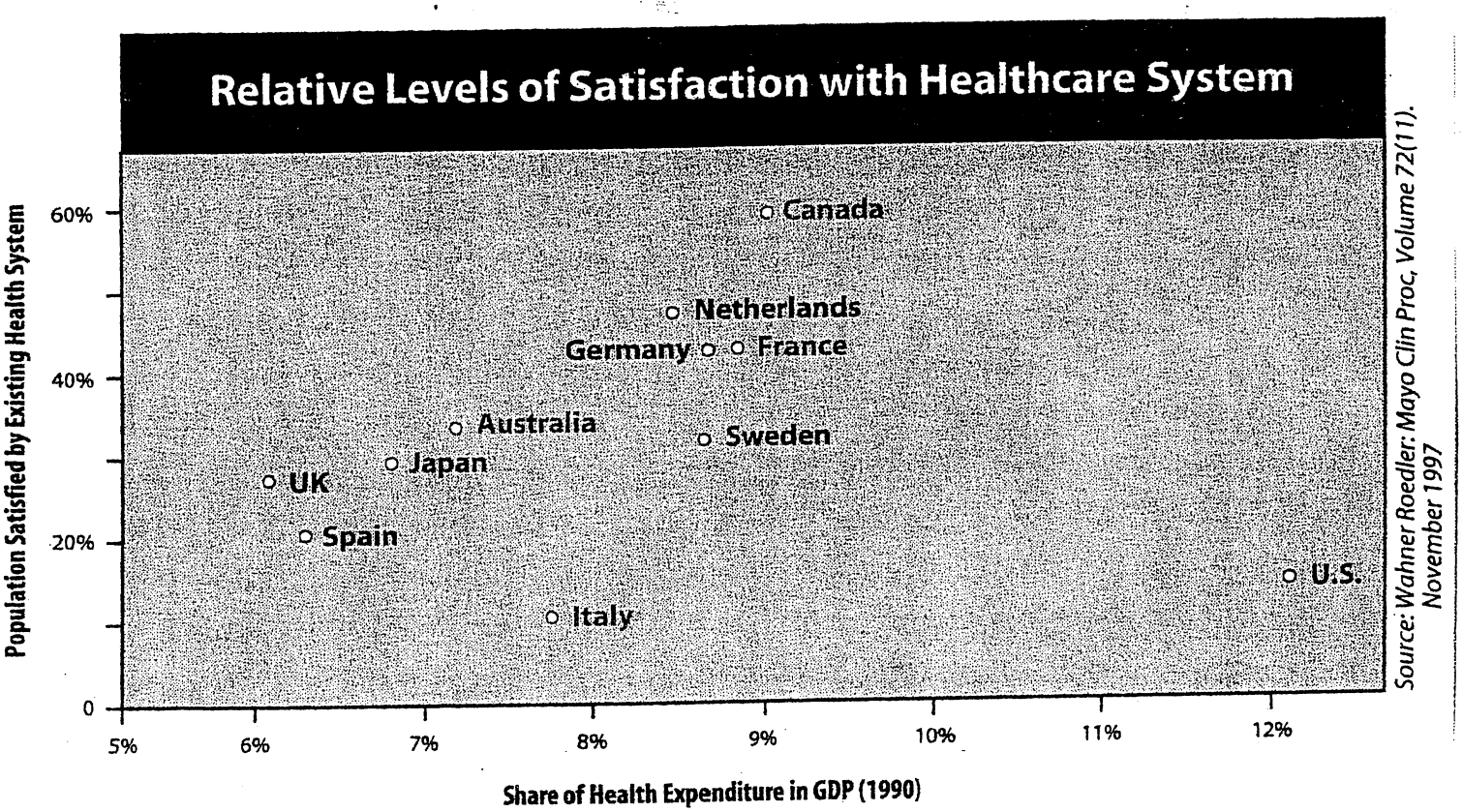

Source: The Shocking Reality of America's Healthcare, AS SICK AS IT GETS, A Diagnosis and Treatment Plan by Rudolph Mueller, MD
Published Feb. 2002 by Olin Fredrick

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Working for Justice in Health Care

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- **UHCAN's quarterly newsletter**, *Action for Universal Health Care*, covers local and national organizing initiatives and provides resources and policy perspectives for advocates.

- **State and local health care justice groups across the U.S. are linked** via monthly conference calls and an email listserv hosted by UHCAN to facilitate information-sharing and joint strategizing.

- **The UHCAN Faith Project** is a unique national interfaith network that provides resources and organizing support for faith-based groups for worship, education and advocacy around health care justice issues.

- **Interaction among national groups and policymakers** to advance a national agenda for universal health care is facilitated by UHCAN.

- **National UHCAN conferences** bring grassroots activists and national leaders together to develop and coordinate strategies to advance universal health care.

- **The UHCAN website** <www.uhcan.org> provides analyses, information, links and resources on health care justice issues and universal health care organizing around the country.

- **Networking, speakers and technical assistance** for local health care justice groups are provided by UHCAN staff and board members. Contact UHCAN to link up with groups and advocates in your area.

UHCAN print resources are by email: ***<uhcan@uhcan.org>***
or cal to request: ***800/634-4442***

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Save the Date! Save th... Date! Sa... e!

Keynote Speaker:

Joycelyn Elders, MD
Former Surgeon General
Professor Emeritus
University of Arkansas
for Medical Sciences

Speakers:

Byllye Avery, MEd, Avery Institute for Social Change

Cynthia Chestnut, Ph.D, Alachua County Board of County Commissioners

Paul Duncan, PhD, University of Florida Department of Health Services Research, Management and Policy

Allyson Hall, PhD, UF Florida Center for Medicaid and the Uninsured

Henry Kahn, MD, Physicians for a National Health Plan

Randy Kammer, JD, Blue Cross Blue Shield of Florida

Moderator: **Vivian Filer, MS, MSN, ARNP**

Gainesville Florida Town Meeting

Health Care is a Human Right!

Health Disparities & Health Care Reform: *A Call to Action*

PK Yonge Performing Arts Center
1080 SW 11th Street (off Archer Road & Depot Ave)
Saturday, March 19, 2005, 1-4 PM
Free of Charge

Sponsors: **The Avery Institute for Social Change and Blue Cross Blue Shield of Florida**

Co-sponsored by **ACORN Clinic, Alachua County Labor Party-Just Health Care Committee, Alachua County Ministerial Alliance, Alachua Coalition for the Homeless, American Medical Students Association, Birth Center of Gainesville, Black AIDS Services and Education (B.A.S.E.), Civic Media Center, Cultural Arts Coalition's Girl Power Program, Displaced Homemaker Program at Santa Fe Community College, Gainesville Area National Organization for Women (NOW), Gainesville Commission on the Status of Women, Inc., Gainesville Community Ministry, Gainesville Women's Liberation, Greater Gainesville Black Nurses Association, FAITH, Inc.- an HIV Community Outreach Program, Florida Traditional School of Midwifery, Iguana, Judy Levy National Organization for Women, N.A.A.C.P.- Alachua County Branch, N.A.S.W. – Gainesville Chapter, Planned Parenthood of North Central Florida, Physicians for a National Health Plan, Rural Women's Health Project, Suwannee River Area Health Education Center (A.H.E.C.), The Sanctuary , Three Rivers Legal Services, UF Association for Academic Women , UF Campus NOW- Women of Color Caucus, UF Center for Women's Studies and Gender Research, UF College of Public Health and Health Professions, UF Department of Health Services Research, Management, and Policy , UF Program for Interdisciplinary Education and the UF Community Rounds Project, UF Women's Health Research Center**

8

Birth Center of GAINESVILLE

The Birth Center of Gainesville is the oldest birth center on the east coast of the United States and is proud to have been "Delivering Florida's Pride and Joy for over 25 years." Our midwives are experts in caring for healthy pregnant women and have a longstanding record of providing high-quality, safe maternity care while helping to grow healthy families and build our community. Over the last 25 years, more than 1,800 babies have been delivered through the Birth Center of Gainesville.

Building Community . . .
. . . *Growing* Healthy Families

"If we are to make real progress in providing primary and preventive care and in reducing infant mortality rates, we must first broaden our provider base by encouraging the growth of midwifery."

- Dr. Charles Mahan, former Florida State Deputy Secretary for Health

Birth Centers deliver safe, cost effective and highly satisfying care!

Research on 11,314 women in 84 centers shows:

Birth centers deliver low intervention care!

U.S. cesarean rate is 26.1%

Birth center cesarean rate is 4.4%

Birth centers deliver cost effective care!

A birth center costs an average of 30% to 50% less than hospital care.

Birth centers deliver safe care *and* healthy babies!

Birth center mothers are less likely to give birth to pre-term or low birth weight babies.

Birth centers deliver highly satisfying care!

98.8% of birth center clients report high satisfaction. Women who use birth centers would return, and recommend birth center care to family and friends.

Rooks, Weatherby, Ernst, Stapleton, Rosen, Rosenfield.
The New England Journal of Medicine, Outcomes of Care in Birth Centers
321.1804-1811.1989

What is a Florida Licensed Midwife?

Florida Licensed Midwives are "experts" in healthy, natural pregnancy and childbirth. Individualized care, education and guidance support good health habits for mothers and families. Midwives care for women in a variety of settings including home, birth centers and clinics.

Midwives Provide Safe, Effective Maternity Care

- Time-intensive quality care and family-centered guidance in the childbearing cycle
- Culturally sensitive education, psychosocial support for improved pregnancy outcomes
- Lower maternity care costs, in part through reduced reliance on cesarean surgery

Midwives provide ongoing risk assessment throughout pregnancy. If medical concerns arise, midwives collaborate with physicians and refer out when indicated. Florida Licensed Midwives must complete three years of academic and clinical education and pass the North American Registry of Midwives national certification examination.

Midwives Model of Care

Recognizing that pregnancy and birth are normal life processes, midwifery care includes:

- Monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle
- Providing the mother with individualized education, counseling and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
- Minimizing technological interventions
- Identifying and referring women who require obstetrical attention

This woman-centered model has been proven to reduce birth injury, trauma and cesarean section.

Florida needs midwives

The Midwifery Practice Act (FS 467) is based on World Health Organization standards and successful European direct-entry midwifery programs. In countries with fewer infant and maternal deaths, lower cesarean rates and lower health care costs than the USA, midwives deliver up to 70% of the babies, with excellent maternal-child health outcomes.

- The United States ranks 22th worldwide in infant survival[1]
- Florida's rate of low birth weight babies is twice as high as in Sweden and Finland[1] where midwifery services are standard care for women with normal, healthy pregnancies (8% vs. 4% low birth weight)
- Women under the care of a midwife have significantly fewer costly cesarean births when comparing similar pregnancy profiles[2]
- Florida's 22.2% cesarean rate ranks 39th within the U.S., with cesarean birth costing twice as much as vaginal births[3]

---

[1] Taylor, Catharine. Giving Birth. New York, New York. Perigee Book; 2002.

[2] Social Science & Medicine, 1993.

[3] Agency for Health Care Administration, 1996.

A Historical and International Perspective

- Post World War II, the United States was the only industrialized country that did not integrate the midwife into the newly evolving health care system.
- Currently the United States ranks 22 in maternal and infant mortality and morbidity.[1]
- Currently the United States spends more per capita on maternity care than any other nation.[2]
- In Western European countries where infant mortality rates are much lower than the United States, midwives attend 75% of births. In the United States midwives attend 7% of births.[3]
- Countries that have the best statistics on maternal and infant well-being are those that rely most heavily on midwifery care.[4]
- The Netherlands has the lowest infant and maternal mortality and morbidity rate. Seventy percent of all births are attended by midwives and one third of the total number of births occur at home.[5]
- After World War II, the place of birth began to shift from home to hospital due to increased federal and state funding for hospitals.
  ~ 1935 - 37% of American women birthed in hospitals
  ~ 1950 - 88% of American women birthed in hospitals
  ~ 1960 - 97% of American women birthed in hospitals
- Currently the United States cesarean section rate is 26.1%; the World Health Organization recommends no more than 12-15% for an industrialized country. A woman is four times more likely to die from a cesarean section than a normal birth.[6]

What is a Midwife?

World Health Organization & International Confederation of Midwives

"A midwife is trained to give the necessary care and advice to women during pregnancy, labor and the postnatal period, conduct normal deliveries on her own responsibility, and to care for the newly born infant as well as having training in gynecology and child care. At all times a midwife must be able to recognize the warning signs of abnormal or potentially abnormal conditions that necessitate referral to a doctor, and to carry out emergency measures in the absence of medical help. A midwife may practice in hospitals, health units or domiciliary services. In any of these situations, a midwife has an important task in health education within the family and community."

For more information about Florida Licensed Midwives contact:

Bob Cerra, Cerra Consultants, Inc.
206B S. Monroe Street
Tallahassee, FL 32301
850-222-4428
rcerra@infionline.net

Layla Swisher, Legislative Chair
Midwives Association of Florida
850-528-1129
MangroveMidwife@yahoo.com

1-5 Taylor, Catharine. Giving Birth. NY, NY. Perigee Book; 2002. p 13.

6 National Center for Health Statistics, June 2003.

Birth Center News

The Birth Center of Gainesville...Delivering Florida's Pride and Joy for Over 25 Years

Winter 2004

A New Chapter for the Birth Center of Gainesville...

It has been an amazing year for midwifery in Gainesville! Here is the most recent chapter of our story.

In 2003 Mary Ann and Dave Smith decided to "hang up their catcher's mitt" by selling the Birth Center of Gainesville (BCG). At the same time Glenn Cameron (Barker), Administrative Director of the Florida School of Traditional Midwifery, spotted a beautiful 120-year-old Victorian mansion for sale on East University Avenue, the historic *Howard-Kelley House.* Glenn arranged a meeting with Dr. Mark and Mary Barrow, the restorers and owners of the house. It was at that meeting that the idea of a Birth and Family Center was born. Then the job of fundraising began for Executive Director Jana Borino.

Photo by Terry Lawrence

The primary funders of the project challenged Jana to demonstrate the community's support of the birth and family center. After nine months of networking, fundraising and just plain old hard work, 39 donors had gifted $285,000, and a $505,000 loan was received from the Florida Community Loan Fund. These gifts formed the foundation for the future work of the birth and family center.

Many have asked "How did you do it?" The honest reply is that we asked. Our supporters were inspired by the potential for real change that a Birth and Family Center will bring to the Northeast Gainesville community.

Our goal is to expand the birth center into a family and health education center providing safe, high-quality, affordable maternity care and support services for families in the Gainesville/North Florida area for generations to come.

We are proud to report that we are doing just that.

Upcoming Events At the Birth Center

~~~~~~

Monthly BCG Information Session
First Tuesday of every month at 6:00PM

~~~~~~~

First Meeting of the BCG Alumni Association
March, 2005

~~~~~~~

18th Annual International Midwives' Day Celebration
May 5, 2005

BCG - Florida's 2004 EPA Project Designee

The Birth Center of Gainesville was chosen by the Florida Consumer Action Network Foundation as Florida's 2004 Designee for the US Environmental Protection Agency's *Change-A-Light/Change-The-World* Project.

Philips Lighting donated 180 energy efficient light bulbs, and two high efficiency gas water heaters were donated by Rianni. These gifts will help the BCG save energy and money. They were presented on November 13 at the BCG's Community Education Celebration.

"We are proud to do our part to help save energy and the environment; we will use the money we save to expand services for low-income families," said Jana Borino, BCG Executive Director.

Photo by Terry Lawrence
~~~~~~~

Three Generations and Going Strong

Logan Roth was born on August 2nd, 2004, at the BCG nearly two weeks past his due date, to proud parents Tera Peeples and David Roth. Logan's birth was the most recent of many "second generation" babies in the history of the Birth Center -- Logan's Aunt Sonya, David's little sister, was also born there in 1982. Even more special was that both Logan and his Aunt Sonya were born into the hands of Birth Center midwife, Selma (Sam) Faucher.

Grandpa Adam, Selma, Baby Logan and David

"On our first visit David mentioned that his sister Sonya was born at the Birth Center. Selma got out the *Book of Life* and showed us where her birth had been recorded on June 26, 1982," Tara said.

Tara went on to explain she was nervous about birth at first. "I couldn't envision myself doing it. But when I met Selma I was immediately calm. Selma is strong and soothing, exactly the person I needed. I felt safe with her."

Logan's grandpa Alan Roth was at hand at the Birth Center to welcome his first grandchild. "I think it's cool that Tera and David chose the Birth Center for Logan's birth. My daughter was born here 22 years ago. Selma (we called her Sam in those days) delivered her and now my grandson Logan."

Aunt Sonya also awaited Logan's arrival at the Birth Center. "I was amazed by the whole experience. Everyone was so awesome, so caring. I want to have my babies through the Birth Center," she commented.

"We started our care in a more clinical setting" said dad David, "and I was always uncomfortable there. I left feeling edgy and in a bad mood. Once we began our care at the Birth Center I was immediately comfortable. It's such a friendly environment. The midwives even let me find the baby's heartbeat at one of the prenatal visits."

"My family was afraid of me delivering the baby at the Birth Center at first" said Tera. "But all of them remarked that Selma soothed them with regular updates during labor. It was soon obvious that we were safe and in good hands. The care at the Birth Center is unbelievably top notch."

"Selma is so wonderful," said Birth Center dad - and now grand-dad - Alan. "Such strength, calm and love. She is the most perfect person to be birthing babies. I am so happy that Logan was born into her hands."

BCG CLASSES & SERVICES

The Birth Center provides family centered classes and services available to the entire community at no cost:

- Doula Services
- Nutrition Classes
- General Birth Center Information Sessions
- Weekly Prenatal Exercise
- Weekly Baby Group
- Weekly Toddler Group
- Baby Gear Class
- Childbirth Education (charge for non-Birth Center clients)

Call today for class times!

Nutrition Corner

IRON WOMAN TRAIL MIX

Mix the following together:

3 c almonds
1 c pumpkin seeds (no roasting, no salt)
1 c sesame sticks (no roasting, no salt, no added flavor)
1 c soy nuts (no roasting, no salt, no added flavor)
1 c sunflower seeds (no roasting, no salt, no added flavor)
1 c dried banana chips (no added sweetener or flavor)
½ c dried cranberries (no added sweetener if possible)
1 ½ c dried figs (no added sweetener)
1 ½ c dried dates (no added sweetener)
½ c dried coconut (no added sweetener)

ENJOY!

Welcome! New Arrivals

- Journey, 9 lbs 10 oz, May 10, to Cindi
- Brance, 6 lbs 8oz, May 22, to Jodi and Troy
- Dominique, 6 lbs 1 oz, May 27, to Sharon and Kenneth
- Isabella, 8 lbs 15 oz, May 29, to Stacy and Jessie
- NoraKate, 8 lbs 13 oz, May 29, to Jacquelyn and Rob
- Rosa, 8 lbs 4 oz, May 31, to Carylee and Jessie
- J. J., 7 lbs 3 oz, June 13, to Tanisha
- Chase Ronnie, 6 lbs 15 oz, June 23, to Keisha and Ronnie
- Layla, 8 lbs 2 oz, June 23, to Joy and Josh
- Ibrehem, 7 lbs 11 oz, June 28, to Hillary
- Galen, 8 lbs 4 oz, June 28, to Christina and Donnie
- Augustus, 7 lbs 13 oz, July 4, to Sylvia and Tom
- Nathaniel Fare, 9 lbs 10 oz, July 5, Amber and Ray
- Indigo, 10 lbs and 6 oz, July 6, to Erica and Randy
- Felipe, 7 lbs 10 oz, July 6, to Kelly and Ricardo
- Inti Restrepo, 8 lbs 13 oz, July 10, to Ysabel and Sergio
- Haileigh Jaid, 6 lbs 3 oz, July 11, to Jackie and Jason
- Reese, 6 lbs, July 11, to Keeley and Ian
- Charlise, 6 lbs 1 oz, July 15, to Crystal and Corey
- Avi Rama, 6lbs 11 oz, July 19, to Chelsea and Jacob
- Ava, 7 lbs 12 oz, July 19, to Laura and Aaron
- David, 8 lbs 8 oz, July 23, to Rebekah and David
- Logan Phillip, 7 lbs 15 oz, August 2, to Tera and David
- Chandramukhi, 7 lbs 8 oz, August 7, to Yamuna and Ragunath
- Emily Olivia, 7 lbs 13 oz, August 8, to Sarah and Richard
- Charley Carl, 8 lbs 5 oz, August 12, to Karla and Charles
- Youssef Adam, 6 lbs 1 oz, August 18, to Gretchen and Brahim
- Houston, 9 lbs 10 oz, August 28, to Celena and Brett
- Cameron, 7 lbs 13 oz, September 5, to Karen and Larry
- Mirin Irie, 7 lbs 4 oz, September 14, to Angela and Ryan

Midwives Hold the Future!

The Birth Center of Gainesville is proud to announce it's new Alumni Association!

The Alumni Association consists of past clients who have benefited from and believe in the value of midwifery care for healthy pregnant women. Its mission is to foster support for midwifery and family wellness issues in Northeast Florida by assisting in activities and events that will promote and sustain the Birth Center and its mission.

To contribute to the Association or be placed on our mailing list, fill out the form below and return it to the Birth Center at 810 East University Avenue, Gainesville, Florida, 32601

Name _____ e-mail address _____

Mailing Address _____

_____

Phone number: day _____ evening _____

❑ I can help with events

❑ Please place me on your mailing list

❑ Please accept my tax deductible contribution of $_____

Make checks payable to FSTM.

Mail to BCOG, 810 E. University Ave, Gainesville, FL 32601

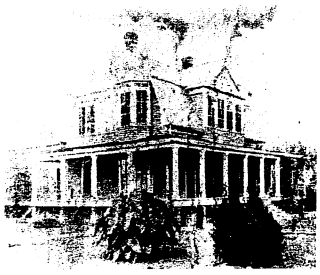
A major funder is matching gifts up to $10,000 between now and the end of the year. Your gift will go twice as far!

History of Howard-Kelley House

The Howard-Kelley Lodge was built in 1882 on the corner Alachua Avenue (now University Avenue) and Palmetto Avenue (now NE 8th Street) by Andrew Howard, president of Alachua Steam Navigation and Canal Company.

In 1925 the house was bought and refurbished by St. Petersburg real estate developer McKee Kelley. Mr. Kelley later built the Dixie Hotel, now known as the Seagle Building.

In the 1980s the house was purchased by Dr. Mark V. and Mary B. Barrow. It was fully restored under Mary's expert supervision and watchful eye. It received the Florida Trust for Historic Preservation Adaptive Use Award for the state of Florida in 1987.



Circa 1918

The History of the Birth Center

Photo by Stewart Thomas

Located in the historic Howard-Kelley House, the Birth Center of Gainesville is the oldest birth center on the east coast of the United States, and is proud to have been "Delivering Florida's Pride and Joy for over 25 years."

Midwifery and the Howard-Kelley House both have a long and rich legacy in our community, a legacy worth preserving and expanding. Over the last 25 years, more than 1850 babies have been delivered through the Birth Center of Gainesville.

The purchase of the Howard-Kelley House for use as a birth and community center has been made possible through a generous loan from the Florida Community Loan Fund.

Birth Center of GAINESVILLE

810 East University Avenue
Gainesville, FL 32601
www.BirthCenterOfGainesville.org

Birth Center of GAINESVILLE
"Delivering Florida's Pride & Joy for over twenty years"
352.372.4784

The FLORIDA SCHOOL of TRADITIONAL MIDWIFERY
"Delivering your Future"
352.338.0766

Jana Borino ~ *Executive Director*

P.O. Box 5505, Gainesville, FL 32627-5505
CELL 352.246.3142
FAX 352.338.2013
jana@midwiferyschool.org
www.MidwiferySchool.org

#4

(9)

Comments on the Florida Medicaid Modernization Proposal

March 14, 2005

By David Wood, MD, MPH
Pediatrician
University of Florida, Associate Professor of Pediatrics
Member, Florida Pediatric Society
515 W. 6th St.
Jacksonville, FL 32206
David_Wood@doh.state.fl.us
Phone: 904-357-5800

I am here to speak on behalf of primary care physicians, pediatricians, family physicians, that see children and adults with special health care needs under Medicaid. Florida Medicaid is often the only resource for children, whose families are among the poorest in Florida, and for disabled populations. For years, Florida Medicaid has failed to provide appropriate access to needed primary health care and case management. This failure is in the form of administrative obstacles and low provider reimbursement, neither of which has substantially improved for over 10 years. My main point is to invest in primary care and case management services under whatever structure is developed for Medicaid in the coming years. One dollar invested in high quality primary care and case management of children and adults with special health care needs will pay off in multiple dollars of savings from hospitalizations and medication costs. Children and adults with special health care needs require high quality, continuous, comprehensive primary care and case management to manage their health issues and prevent deterioration in function.

Primary care is under funded. Florida Medicaid pays physicians only about 60% of what Medicare pays, which is markedly less that what it costs to provide the care. By not funding their time adequately, physicians, who need to stay in business, can not spend the time needed with individuals and their families and case managers to make sure the care they need is provided. Health care case management is a very important compliment to primary care. Case management services are available for only selected populations, such as children enrolled in Children's Medical Services or children with severe emotional disturbance. Adults have almost no access to health care case management. For example, adults with developmental disabilities under the Medicaid Home and Community-Based Waiver receive case management for help with employment, independent living and other issues, but nothing for medical case management. The Medicaid waiver is spending over $20,000 per person for support services—desperately needed and greatly appreciated—but nothing for medical case management support. Over half of this population has serious medical and mental health issues, but they are left to navigate the health care system on their own. As a result, they and other special populations depend on under-funded primary care doctors to provide case management as well as general medial care. Case management takes a lot of time. It doesn't happen. As

a result, the neediest individuals fall through the cracks; they get on multiple, conflicting medications; they get sick and have to be hospitalized or they simply live with suboptimal health and function. Physicians make up 4% of the Medicaid dollar, but the lack of adequate primary care and case management results in the wasting of many times this amount, while having a seriously detrimental impact on the health of children and adults. Please fund primary care adequately—at least at the Medicare rate, which other states have done. And fund more case management for populations with special health care needs. Not only will you save money, the health of the population of Florida's neediest citizens will be better off for it.

Thank you.

(10)

The Florida Legislature
Senate Select Committee on Medicaid Reform
House Select Committee on Medicaid Modernization
Public Hearing Comment Form

Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately $14.4 billion (24% of the entire state budget) and are projected to more than double to $36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review. If you wish to mail this form or email your comments, please send to:

Senate Committee on Health Care
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100
e-mail: Medicaid.Reform@flsenate.gov

Name: Karin Clatterbuck
Association: Self & Florida Institute for Family Involvement
Address: 7 Sunset Blvd
Ormond Beach, FL 32176

(*Please use the front and back of this sheet to provide your information.*)

1st I would like to invite the Committee, all Legislators, Gov. Bush and his staff to meet with families on how this "reform" affects us all. Including our ideas and objectives

→

opinions on how Medicaid can be "Improved" to better facilitate our communities needs and become more cost efficient. We, at consumer level, will know what is working, and what will not.

2nd

2 minutes is not enough to afford any or enough combined thoughts or ideas to legitamately make a verbal impact on this issue.

Before any services are changed for our citizens, we should have a more fluent opportunity to express the needs of the many.

Thank you, Karen L. Clatterbuck

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House Select Committee on Medicaid Modernization
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(Please use the front and back of this sheet to provide your information.)

I would like to request that at the least, the Committee speak closely with Florida's Children's Medical Services. The Nurse Care Coordinators know first-

hand what families suffer with daily in the effort to receive services. They work to ensure the health & well being of all of these families and their children and understand the scope of this dilemma. As well, they are extremely familiar 1st hand at what in our system works successfully, and what doesn't.

Thank you,

Laura L. Cotter Burke

FLORIDA MEDICAID

JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

October 25, 2004

Dear Medicaid Provider:

As you work with children through the Medicaid program, I know you want to do all you can to meet the needs of children with medically complex conditions or who need medical care over a long-term period.

If you are relying only on private duty nursing services for these patients, I hope you will consider Prescribed Pediatric Extended Care Services, also known as PPEC services.

Florida has more than 20 PPECs specifically designed to provide high-level medical care in a non-residential pediatric center. They are staffed by registered nurses and other health professionals who are trained to work with three or more children requiring specialized medical care. The PPECs offer services that meet the child's physiological, developmental, physical, nutritional and social needs. Children can stay at a PPEC from as little as one hour to as many as 12 hours a day.

Medicaid continues to provide private duty nursing services when needed. However, PPECs are more cost effective, less restrictive, and they reduce the isolation that homebound children can experience. In addition, PPECs provide a central location for other needed services such as therapies or parent training.

I appreciate the work you do for Florida's children, and I hope you will make PPEC services an integral part of your care planning.

Sincerely,

Thomas W. Arnold
Deputy Secretary for Medicaid

2727 Mahan Drive • Mail Stop #20
Tallahassee, FL 32308

Visit AHCA online at
www.fdhc.state.fl.us

Alliance of Florida PPECs

Caring for Florida's medically fragile children

MARCH 14, 2005 PRESCRIBED PEDIATRIC EXTENDED CARE

Brightstart Pediatrics
Orlando

Caring for Kids/
Caring Hearts
Pediatric Care Center
Naples/Pensacola

Children's Care
Campus/Children First
Orlando

Children's Hospital
Extended Care Center
Fort Myers

Children's Rehab
Network
Miami (2 locations)

Fletcher's Tender Care
Jacksonville

Jackson Infant/Toddler
Center
Miami

Kids Medical Club/PSA
Melbourne,
Jacksonville, West
Palm Beach, Orlando

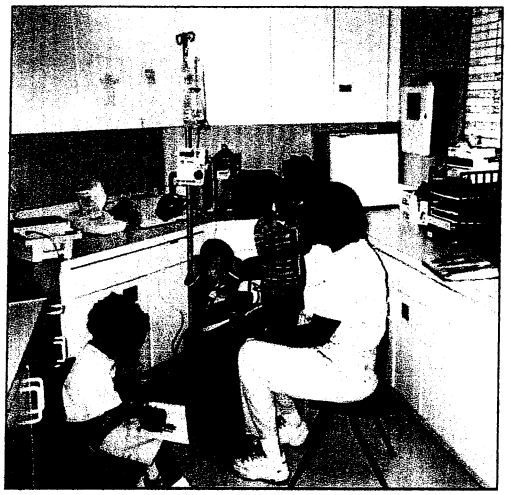
Tender Care Centers
Fort Lauderdale

Referral sources:

- Children's Medical Services
- Physicians
- Hospitals
- Home health agencies
- Nursing agencies
- Schools
- Social workers

PPECs serve medically fragile kids

A PPEC, or Prescribed Pediatric Extended Care, is a licensed, non-residential center for children with medically complex conditions. Care is provided by a team of skilled professionals up to 12 hours a day. PPECs are an excellent alternative to more costly residential and home health care.



PPECs provide interaction with other children while giving parents the opportunity to return to work or school.

We care for children with:

- Diabetes
- Cardiac/kidney disease
- Burn care
- IV therapy
- Tracheotomy care
- Colostomy care
- Post-transplant care
- HIV
- Other conditions

Important facts about Florida PPECs

The majority of the children we serve are under the age 3. They are healthy enough to be discharged from the hospital but still need constant medical supervision. Day care centers cannot care for them.

There are at least 66,000 medically fragile children in Florida, and many could qualify for PPEC services, according to a 2003 legislative report.

PPECs annually serve about 800 children, according to the legislative report.

Our services are TEN times less expensive than home health care.

Services to eligible families are currently covered by Medicaid, but we don't know what will happen under Gov. Jeb Bush's reforms.

Unlike other pediatric providers who received a Medicaid rate increase last year, PPECs have not seen one in 18 years.

MEDICAID SPENDING ESTIMATES

- The relevant comparison in assessing the growth in Medicaid expenditures is Medicaid as a percentage of the state's general revenue (GR) budget not the total state budget. Federal and local funds represent much of Medicaid spending. For example, estimated total Medicaid spending for FY 2004-05 is $14.95 billion, but the GR share is estimated at $4.12 billion, 27.6% of the total. Almost all of hospital inpatient expenditures are financed by federal and local funds.

- In FY 2003-04, Medicaid represented 14.6% of the state's GR spending, compared to 22.7% of total state spending. In fact, Medicaid as a percentage of state GR spending was 14.1% in FY 1994-95, only a small change compared to Medicaid GR spending a decade later (only a 3.5% increase in 10 years).

- Florida Medicaid has a favorable federal matching rate – nearly $.60 of every dollar of Medicaid funds comes from the federal government. These federal funds provide a substantial investment in care for lower income individuals, reduce uninsurance rates, and support the state's safety net providers.

- Every $1 in state Medicaid spending in Florida generates an additional $3 in new business activity – a threefold return in state economic benefit; it is estimated that Florida Medicaid spending accounts for almost 175,000 jobs and $6.5 billion in wages.

- Despite the growth in Medicaid spending, Florida has a very conservative program, ranking 42nd among the states in per capita spending. Increases in recent years can be traced to population growth and demographics (nursing home spending increases).

- Health care spending for low income individuals occurs whether it is financed by Medicaid or not. Reductions in Medicaid coverages to reduce state spending will result in the loss of federal funds and simply lead to increases in uncompensated care (e.g., hospitals) and a shift in costs to employers, insurers, other payers, other programs, local government and providers.

- A considerable portion of Medicaid spending still results from fraud and abuse. A picture of Medicaid spending would be much different if wasteful spending were eliminated.

- Medicaid cannot be reformed in a vacuum. Reductions in Medicaid coverages could lead to increased costs in other programs. Restrictions in access to psychotropic medications, for example, could lead to poorer patient outcomes; increased public safety, juvenile detention and correction costs; greater homelessness; and additional school failures.

- More than 50% of Medicaid spending is for 5% of the Medicaid population. Effective targeted approaches in treating the chronically ill, disabled population could have a substantial effect on new Medicaid spending without reforming the entire program.

- **Even if additional controls on state Medicaid spending are necessary, it is essential that various elements of the program be viewed separately. Medicaid mental health spending has remained relatively constant over the year and is already being converted entirely to managed care at a substantial discount and at a faster pace than other Medicaid benefits.**

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- **Even if additional controls on state Medicaid spending are necessary, it is essential that various elements of the program be viewed separately. Medicaid mental health spending has remained relatively constant over the year and is already being converted entirely to managed care at a substantial discount and at a faster pace than other Medicaid benefits.**

FLORIDA COUNCIL
2/16/05

MEDICAID SPENDING ESTIMATES

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2/16/05

Testimony from the Commission for the Transportation Disadvantaged
Lisa Bacot, Executive Director
605 Suwannee Street, MS 49
Tallahassee, FL 32399-0450
(850) 410-5711 or lisa.bacot@dot.state.fl.us

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Good afternoon, my name is Lisa Bacot, I'm the Executive Director of the Commission for the Transportation Disadvantaged. Thank you for the opportunity to speak to you today.

The coordinated transportation system in Florida is the recognized leader in the nation. The Commission has been awarded the National Award for State Leadership from the Federal Transit Administration in 2004 for our statewide efforts to provide more and better transportation services, while reducing costs. Also, in 2004, the Commission received a National Award for Excellence from the Community Transportation Association of America.

The Agency for Health Care Administration, or ACHA, conducted an independent study in 2003 to assess if the coordinated transportation program was indeed saving money to the State of Florida. The results that revealed that the TD Program had indeed saved the State up to **$41 million in FY 2002**. As you can see from the chart provided, the Medicaid agency was spending $105 million in FY 1995 on non-emergency transportation program, the current allocation for FY 2005 is $72 million. This is a ***28%*** reduction in the last decade. Quite an accomplishment.

In an effort to continue cost savings for the State, the Commission and AHCA created a new program and signed a contract between the two agencies in June of 2004. Under this new

program, the Commission is paid a fixed fee, per month, similar to the capitated method proposed under the Governor's Medicaid Reform Plan. The Commission in turn contracts with the same entities required by law to provide or arrange transportation services to transportation disadvantaged citizens. I'm excited to report that the current program is up and running, working well, and is 100% compliant with Chapter 427, Florida Statutes.

It is my understanding that the currently proposed Medicaid Reform will allow Managed Care Organizations the choice of whether or not they would like to provide Medicaid Non-Emergency Transportation (NET) services to eligible beneficiaries. If this is allowed to happen, this could be a detour from coordinated efforts already being utilized and proven to be cost-effective. The cost-savings realized by coordinating transportation services, in other words, multi-loading clients from differing agencies, such as Medicaid, Transportation Disadvantaged, Elder Affairs or Development Services, may be lost.

Another area of concern, is accessibility of services for consumers. If Managed Care Organizations choose to provide NET services, the clients will have to call one number for Medicaid transportation and yet another phone number for Transportation Disadvantaged Trust Fund service or other types of transportation services that are currently coordinated. It's our concern that this would confuse consumers and create a disruption in services.

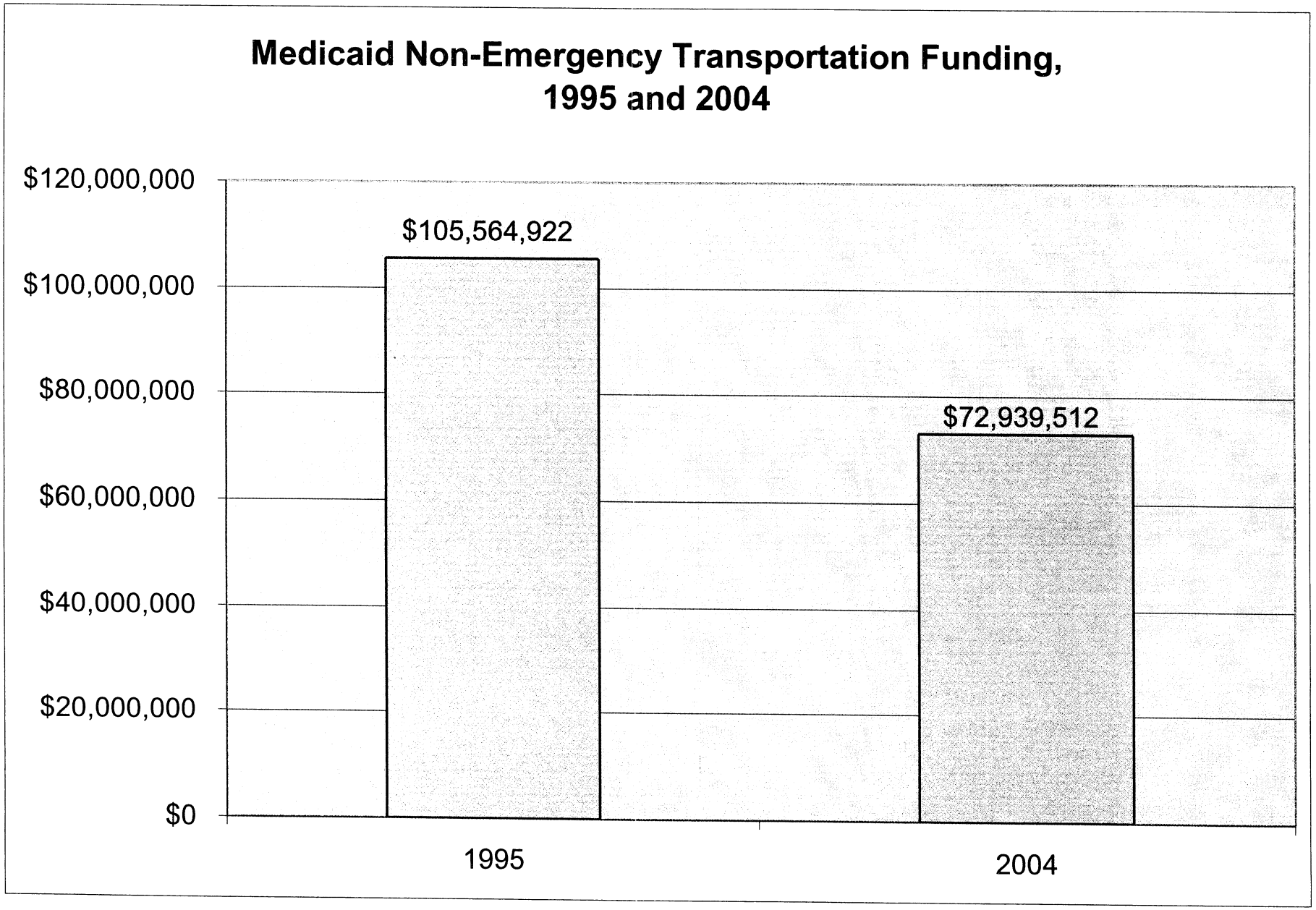
The Commission and ACHA have already begun reform efforts that are based on a fixed fee per month basis. Stability and cost savings have been achieved in this program. The Medicaid Non-Emergency Transportation (NET) Program administered

by the Florida Commission for the Transportation Disadvantaged (Commission) should remain exempt from the Medicaid Reform efforts.

I applaud the Governor, AHCA and the legislature for taking a bold step in attempting to control costs in the Medicaid program, I'm proud that Non-Emergency Transportation has already taken a step forward to tackle this challenge.

Please keep the current contract in place between AHCA and the Commission and keep the Non-Emergency Transportation Program separate from the proposed Medicaid Reform efforts.

Thank you for the opportunity to speak today.


Medicaid Non-Emergency Transportation Funding,
1995 and 2004
$120,000,000
$100,000,000
$80,000,000
$60,000,000
$40,000,000
$20,000,000
$0
$105,564,922
$72,939,512
1995
2004

All Saints Catholic Nursing Home and Rehabilitation Center
5888 Blanding Boulevard, Jacksonville, Florida 32244
Phone: (904) 772-1220 Fax: (904) 772-6334

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All Saints Catholic Nursing Home & Rehabilitation Center
Medicaid Reform Hearing
Jacksonville, FL
March 14, 2005

Facility Bio

All Saints Catholic Nursing Home & Rehabilitation Center opened over 50 years ago in Jacksonville, Fl as a way to meet the needs of the elderly who cannot otherwise care for themselves. It is a non-profit facility that has expanded from 6 residents to 120 residents, and has increased the services delivered to include physical, occupational, speech therapy as well as a secured Alzheimer's Unit.

Since 1955, All Saints has been known for quality care. Just last year, All Saints was recognized by:

- ☆ Florida Health Care Association for having the Nurse Administrator of the Year
- ☆ The Florida QIO for Medicare for Best Practices regarding Pressure Ulcers
- ☆ American Health Care Association for a Step I Quality Award
- ☆ Deficiency-Free survey October, 2004

Current Crisis

All Saints has always strived to provide care for those who cannot afford it, and even provides charity care for individuals when possible. However, in the past couple of years All Saints has been struggling to break even financially without compromising quality. Here are some brief bullet points on concerns for the facility:

- ✓ All Saints has approximately 63% Medicaid residents; 20% of which have diverted assets in order to qualify for Medicaid.
- ✓ In 2004, All Saints received more than $2.2 million to care for Medicaid residents; with more than $445,000 covering the residents with diverted assets (cost to the state of Florida).
- ✓ 2003 audited figures show Medicaid per patient day revenue of $124.33
- ✓ 2003 audited figures show expenses per patient day of $133.76 (a loss of more than $245,000 for the year).
- ✓ Staffing increases from 2.3 to 2.6 direct care CNA staffing

- ✓ July, 2004 indirect component *recurring* cut of $2.58 per patient day, resulting in a loss of approximately $40,000.
- ✓ All Saints increased private pay rates by 4% in 2004, and 10 months later an additional 5%.
- ✓ All Saints had to lay off staff and consolidate positions, as well as give employees lower pay increases than desired.

Medicaid Reform

The Board and staff of All Saints recognize the need for changes within the Medicaid system. However, we firmly believe that before making any radical changes, the system should be examined for cost-effective spending and appropriate revenue management.

Example 1: The diversion of assets was originally developed to ensure that the spouse of a loved one would have enough funds to care for themselves while their spouse was in a nursing home. However, we have had at least one Medicaid resident whose wife had diverted more than 6 properties, several mutual funds, and a significant amount of cash. How can this be fair when the resident does not have to pay their own way, but the taxpayers foot the bill? As noted above, diverted assets cost Medicaid approximately $445,000 in 2004. We believe that a certain percentage of that could have been saved by the state of Florida if the laws allowing the diversion of assets had been restructured to ensure that those who can afford to pay for their care.

Example 2: Are all facilities meeting their CON requirements (or all other requirements for participation in the Medicaid program)? If not, are they fined appropriately?

Example 3: Could pharmaceutical spending (one of the greatest cost increases annually for Medicaid) be limited by limiting advertising by pharmaceutical companies? Is it ethical for the pharmaceutical companies to advertise when the physicians are the ones who should be deciding what medications are appropriate rather than the consumer?

Conclusion

All of us at All Saints Catholic Nursing Home are grateful that the Medicaid program is being reviewed for alternatives. However, we urge caution and conservatism for those involved in the overhaul of the system. Maybe if we look to tighter management of the current system, we could find enough untapped funds to help with the anticipated shortfall, and allow you to have more time in developing a newer, more cost effective system that will meet the needs of the public. We appreciate the opportunity to share our story, and will help you in any way we can. Often those developing the systems will not ever be recipients of the program, and they should take time to hear the concerns as you have been. Thank you for your time!

Contact Person: Connie O'Donnell, Administrator
(904) 772-1220, ext. 222
codonnell@allsaintsnursing.org

The Florida Legislature
Senate Select Committee on Medicaid Reform
House Select Committee on Medicaid Modernization
Public Hearing Comment Form

15

Florida's Medicaid program provides health care services for low-income, elderly, and disabled persons. The program currently covers over 2 million Floridians. The concern is that the state expenditures for the Medicaid program are growing faster than the state's revenue growth. In 2004-05, Medicaid expenditures are approximately $14.4 billion (24% of the entire state budget) and are projected to more than double to $36 billion by 2015. As the program continues to grow rapidly, it leaves fewer dollars available for other public needs like education and transportation.

The purpose of this public hearing is to gather information from Medicaid recipients, health care providers, and other interested parties who may be affected by changes to Florida's Medicaid program. We need your ideas on how to reduce the rapid growth in Medicaid expenditures while continuing to provide needed services to Florida's low-income, elderly, and disabled. The Committees will also accept any comments you may have on the Governor's proposal to reform Medicaid.

Please use this form if you would like to provide information to the Committees, but do not want to speak during the public hearings. All forms will be made available to the Committee members for their review. If you wish to mail this form or email your comments, please send to:

Senate Committee on Health Care
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100
e-mail: Medicaid.Reform@flsenate.gov

Name: María Elia Moga Posas

Association: Student.

Address: 1955 Normandy Drive #3
Miami Beach, FL 33141

(Please use the front and back of this sheet to provide your information.)

I would like to know how would the proposed reform will affect Miami-Dade County where 28% of the population lives in poverty and depends on Medicaid or Medicare and SSI for health coverage.

How would it affect Jackson Memorial Hospital?

The Florida Legislature
Senate Select Committee on Medicaid Reform
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e-mail: Medicaid.Reform@flsenate.gov

Name: Jeff Goldhagen M.D

Association: _____

Address: 515 W 6TH ST

Jacksonville FL 32206

(Please use the front and back of this sheet to provide your information.)

Transforming Medicaid

Jeff Goldhagen, M.D., MPH
Director, Duval County Health Department
Associate Professor of Pediatrics
University of Florida

"For every complex problem there is a simple solution, and it's wrong."

H.L. Mencken

Medicaid is complex and far beyond the capacity of any but those who study it as a profession to fully comprehend. Even those among us immersed in it every day are frequently amazed by the complexity of its architecture. Like the study of matter or religion, the challenge is to be able to reduce it to its most fundamental elements in order to better understand how it works. The following is an attempt to do this. A summary of concrete recommendations is provided first, followed by a more in-depth description of the recommendations. Finally, a brief rationale for some of the suggestions is provided. They do not represent the position of the Department of Health, but rather reflect 30 years of domestic and international experience in the health profession, and more than a decade of work in public health in Jacksonville.

Summary Recommendations

1. **Support the Governor's commitment to transform Medicaid.**
2. **Move beyond "privatization" and the "marketplace" as the organizing principle for this transformation.**
3. **Reinvent AHCA to become the *Agency for Innovation in Health Systems Development.* Move the Agency's primary function from regulation to systems planning and expand its relevant professional expertise and resources. Charge this new Agency with using and/or developing emerging and new technologies to improve the efficiency and effectiveness of care. Medicaid should not only be about delivering health services, but also health outcomes.**
4. **Integrate this Agency with the Department of Health and the mental health components of DCF.**
5. **Develop the new Medicaid Model as a "*Health Utility*"—using the public-private sector principles that define the framework and governance of Utilities. (It works for other essential services, e.g., electricity, water, transportation, etc., what is different about health?)**

6. **Model the successes of other State programs that transfer state and federal resources to the community for them to develop their own innovative systems (e.g., Healthy Start, School Readiness, Public Schools, etc.).**
7. **Use the Kaiser Permanente and other national and international models that have an evidence-base to develop county-specific or region-specific health systems. Use the new Agency's expanded expertise to support counties in this endeavor.**
8. **Integrate the current County Health Department infrastructure and other county-specific health system assets into the system of care. Maintain cost based reimbursement for Health Departments and Community Health Centers that rely on these resources to sustain their viability.**
9. **Build a Pharmacy System using formularies, competitive drug pricing, and the 330 and 340 state and federal drug purchasing programs. Apply new technologies to make the system more cost-effective.**
10. **Do not "balance" the Medicaid budget by limiting health services to women, children and other populations of vulnerable citizens. Instead, expand these prevention services.**
11. **Conceptualize Medicaid as a revenue maximization program and look at ways to expand it to leverage increased federal dollars. In particular, do not sacrifice the disproportionate share and upper payment limit components of Medicaid. Recognize the positive economic impact Medicaid expenditures have on communities, expenditures that are covered primarily by the federal government.**
12. **Expand and take advantage of other related programs, in particular the State Child Health Improvement Program (SCHIP), to provide maximal access to services covered by programs other than Medicaid.**
13. **Move beyond cost to focus on quality and outcome improvement as the measures for success. Recognize that Medicaid serves the most complex, highest risk, and most vulnerable of our citizens. Simple solutions, like "privatizing" and "market competition," are as Mencken suggested, simple solutions that will inevitably be wrong.**

Recommendations

*1. **Support the Governor's commitment to transform Medicaid.*** Support the Governor's commitment to restructure Medicaid, but modify the primary motivation and context from saving costs to using this resource to facilitate establishing a ***"system of care"*** for those who require public support to access health services in Florida. This would include those insured by Medicaid, as well as the uninsured. Successes in developing and improving this system and the health infrastructure will benefit all citizens of the state, not just those receiving direct support from Medicaid.

*2. **Move beyond "privatization" and the "marketplace" as the organizing principle for this transformation.*** Privatization and the marketplace are economic strategies and

political constructs that do not relate well to the practice of medicine. The Health Sector does not act like a traditional market, and privatization and competition preclude the capacity of public-private sector collaboration to create efficient and effective systems of care.

*3. **Reinvent AHCA to become the Agency for Innovation in Health Systems Development.*** Reinvent AHCA to move it from an "Administration" Agency focused primarily on regulation, to become the ***Agency for Innovation in Health Systems Development***. This change is much more than just semantics, it is a fundamental reorientation that will transform Florida's capacity to meet the future challenges we face. The US has the best doctors and hospitals in the developed world, but the worst health care system. This new Agency would help to correct this imbalance for Florida.

*4. **Integrate this Agency with the Department of Health and the mental health components of DCF.*** Link or integrate this new Agency with the Department of Health. The state is spending hundreds of millions of dollars in population and personal health through the Department of Health. It makes sense to integrate the resources of these Executive Branch agencies to establish and sustain a holistic system of care. Consideration should also be given to moving the responsibility for mental health from a social services agency (Department of Children and Families) into a Health Agency. The current structure reflects a 19th century "Cartesian" approach to mental health and not a contemporary understanding of the immutable link between physical and mental health. How can you expect the Health System to work if you dismember the body?

*5. **Develop the new Medicaid Model as a "Health Utility"—using the public-private sector principles that define the framework and governance of Utilities.*** Develop a "***system of care***" that moves beyond "privatization" as the organizing principle, by using Medicaid resources to establish "***Health Utilities***," modeled after benchmark programs like Kaiser Permanente and the Jacksonville Electric Authority. Bidding out health care will perpetuate the current delivery of disjointed health services and negate the opportunity to develop an integrated, holistic, efficient and effective health care system. Developing the system as a ***Health Utility*** will facilitate its utilization and development of new and emerging technologies, a critical function of all utilities.

*6. **Model the successes of other State programs that transfer state and federal resources to the community for them to develop their systems of care (e.g., Healthy Start, School Readiness, Public Schools, etc.).*** Allow counties to play a much greater role in the development of their local health systems. Each county is different and each is currently investing large sums of their own money and other resources in the delivery of health services and public health. Allow counties to integrate their safety-net systems with those of the state. Florida has taken a lead in doing this with other systems, in particular and most recently, Early Childhood Education. Use these successes as examples of what could be accomplished with the delivery of health services. Engaging the private and public sectors at the local level in this endeavor will help ensure they become and remain fully invested in the development and sustainability of this system of care.

7. Use the Kaiser Permanente and other national and international models that have an evidence-base to develop county-specific or region-specific health systems. Charge the new Agency with developing the expertise to support counties in this endeavor. There are recognized models of health systems that have proven successful from both a cost and a quality perspective. As a reinvented Agency charged with developing innovative health care delivery systems, it makes sense that examples and analyses of national and international benchmark models be provided to communities, and expertise be developed by this new Agency (health economists, social scientists, health educators, epidemiologists, physicians, social marketing, etc.) to provide technical assistance to help communities succeed in these new endeavors.

8. Integrate the current County Health Department infrastructure and other county-specific health system assets into the system of care. Leverage all the assets and resources of communities, including County Health Departments and Community Health Centers (FQHCs), to build this system. Maintain their reimbursement structure that leverages federal resources to ensure their viability and sustainability. Move beyond the individual clinical "health care" model to take a population-based perspective that includes prevention and responding to health disparities as supporting pillars of the initiatives.

9. Build a Pharmacy System using formularies, competitive drug pricing, and the 330 and 340 state and federal drug purchasing programs. Pharmacy costs are among the fastest growing and most expensive components of Medicaid. Yet surprisingly, most Medicaid recipients purchase their drugs at retail cost to the state! This is despite the ability of the state to purchase drugs at significantly reduced costs. The County Health Departments, for instance, purchase drugs at discounted costs, as do Community Health Centers and the Veterans Administration. Significant cost savings could be obtained by simply purchasing drugs at costs that are negotiated using the "buying-power" of the state, and applying new technologies to their prescribing, procurement and distribution.

10. Do not "balance" the Medicaid budget by limiting health services to women, children and other populations of vulnerable citizens. Instead, expand these prevention services. Nearly 50% of all births in Florida are paid by Medicaid and more than 50% of all those receiving benefits are women and children, yet they account for less than 20% of the costs. These are preventive services that will save the State many fold more than they cost.

11. Conceptualize Medicaid as a revenue maximization program and look at ways to expand it to leverage increased federal dollars. The Federal government pays 60 to 70 cents for every 30 to 40 cents the State pays for the costs of Medicaid. Given the historical demographics of the state, the rapidly approaching "future" of the baby-boomers, and the contribution of federal dollars to cover the costs of care to our most vulnerable citizens, although it may seem heretical, perhaps we should be seeking ways to expand Medicaid, not contract it. This is particularly true with respect to DSH and

UPL that leverage Federal dollars to support the hospitals that serve our most vulnerable communities and educate our future health professionals.

12. Expand and take advantage of programs, in particular the State Child Health Improvement Program (SCHIP), to provide maximal access to services covered by programs other than Medicaid. Virtually none of our health care programs are integrated. If 100,000 children are dropped from the roles of SCHIP because of state policy decisions, as has occurred over the past year, this will have an impact on Medicaid (one of the most common reasons for bankruptcy is medical costs). Whenever possible, programs that directly or indirectly impact Medicaid (SCHIP, Medicare, SSI, Mental Health, etc) should be strengthened and expanded, and strategies developed to integrate them into a holistic system of care that includes Medicaid.

13. Move beyond cost to focus on quality and outcome improvement as the measures for success. Recognize that Medicaid serves the most complex, highest risk, and most vulnerable of our citizens. Medicaid serves low income, people with multiple co-morbid conditions, the elderly, the mentally ill, etc.—put simply, our most vulnerable and marginalized citizens. Conceptualizing and solving the Medicaid "problem" as an economic cost issue is inconsistent with its realities, and solutions built on this model will fail. Profits cannot be generated like in other private sector businesses and this marketplace doesn't function like traditional markets. ***Solutions, like "privatizing" and "market competition," are as Mencken suggested, simple solutions that will inevitably be wrong.***

Rationale

System of Care. A system of care for people insured by Medicaid does not exist in Florida. We have a disjointed market driven entity (not a system) that is built on a profit motive with little to no accountability for population-based health outcomes. Our electric companies, water companies, transportation systems, etc., do not run this way—we should consider applying our experience with these public resources to our publicly-financed health "system."

Health Utilities. Consider our Electric Utilities, Water Companies, Port Authorities, and the way we have developed other public sector entities that require a large capitalization, an economy of scale and public accountability—based on cost and a return on investment. They work—so shouldn't our publicly-financed health systems be developed and managed like a utility—a semi-public, public-private sector partnership that is managed by professionals and governed by a reputable and competent Board to deliver a quality service at a competitive price point, with "profits" reinvested in the system.

Kaiser Permanente. It works. Think of it as a *health utility.* Could we think in terms of implementing Kaiser Permanente *health utility* look-alikes in regions throughout the state?

Market Drive Competition. It works for janitorial services, but do we really want to develop our health care system by awarding contracts to the lowest bidders who use their profits to reward investors, as opposed to fully investing them in expanding the breadth, depth and quality of services. Health care does not conform to the rules of traditional markets. If it did, we wouldn't have the worst disparities and among the worst life expectancies of any developed country in the world, and spend vast amounts more than any country for these poor outcomes! If it worked, we would have happy and satisfied consumers, providers, hospitals and other stakeholders.

Managed Care. It works well as a health delivery strategy, but managed care as a delivery strategy should not be considered as synonymous with the business strategy of managed care. Managed care is an effective approach to improve health outcomes. The business of managed care is based on generating profits, not population-based outcomes.

Managed Care Companies. In Jacksonville, we've had more than 10 Medicaid Managed Care companies over the last 10 years that have come and gone, impacted the community's attempts to develop a system of care, confused patients, and have not been held accountable nor contributed to our community's overall health outcomes.

Evidence-Based. For those in the private sector, the standard is to apply due diligence and analysis to any business operation. A system of care must be held to the same standards--to be evidence-based and data driven.

AHCA. Despite its best intents and knowledgeable people, it hasn't worked to its fullest potential. This is primarily because its main functions are regulatory and to distribute public sector resources. This Medicaid reform effort of the Governor is a great opportunity to redefine the role of AHCA to move beyond "Administration" to health systems planning, development, and implementation.

Leverage. In the process of developing this holistic system of care, Florida's public health system, that is arguably the best in the country, should be considered as an asset and platform to support these endeavors. There are 67 public health delivery systems in 67 counties that can be leveraged as an integral part of the implementation of a system of care. If neglected or destroyed in an effort to reform Medicaid, it cannot be rebuilt. Whatever solutions to Medicaid evolve, they should include an investment in the Public Health system to sustain and expand its value to the state.

Working Poor. Medicaid reform should include a consideration of ways to develop a system of care that goes beyond just serving Medicaid-eligible people (who change every day), to address the growing needs of the uninsured. This is a tremendous opportunity to leverage Medicaid dollars and other sources of support to create a health care "safety-net" system that serves all of Florida's residents in need.

Revenue Maximization. It is perhaps a heretical thought, but should we be looking at how to expand Medicaid and not limit it. The problem and challenges are not going

away. Given that: (a) the great majority of Medicaid dollars are spent to pay for the care of the elderly, nursing home costs and the disabled, (b) that the number of people who need these services in Florida, in particular elder care, will continue to increase, and (c) the Federal government is paying for the majority of these costs under the current system, it seems counter-intuitive to try to limit the investment of Federal dollars to cover the costs of the programs. Cost savings should come from improving the efficiency of services, not limiting them.

Conclusion

Alexander de Tocqueville once said that "America is great, because America is good." Ensuring access to health services to all in a community is a measure of American goodness. Medicaid reform done in the right way, for the right reasons and in the right context, provides us an opportunity to sustain and expand America's goodness. Governor Bush should be applauded for attempting to ensure that Medicaid is sustainable in Florida.

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Medicaid Waiver Briefs: Potential Impact of a Section 1115 Medicaid Waiver on Duval County, FL

Presented by the

First Coast Coalition for the Uninsured

November 2004

DCHD
DUVAL COUNTY HEALTH DEPARTMENT

Introduction

The First Coast Coalition for the Uninsured's mission is to champion health care coverage and access to health care for uninsured people in Duval County. The Coalition's commitment includes monitoring and disseminating information to the public and policymakers about issues related to the impact of being uninsured, and the realities faced by people without health care coverage and/or access to health care in Duval County. Toward this end, the Coalition is distributing the enclosed set of policy briefs on a proposed "Section 1115" Medicaid Waiver for the state of Florida

A "Section 1115" Medicaid waiver allows any state to conduct experimental, pilot, or demonstration projects which assist in promoting the objectives of Medicaid. It allows a state to test new ideas. Florida is considering a waiver application that would privatize much of Medicaid and cap expenditures. This 1115 Medicaid waiver could not only affect those with Medicaid coverage and those struggling without health insurance, but also many people in the county who rely, perhaps unknowingly, on the federal dollars brought in through the Medicaid program for jobs, income and other economic benefits.

These briefs were developed by the Duval County Health Department's Institute for Health, Policy and Evaluation Research. The Institute prepared the analysis in response to community requests for Duval County-specific data related to the projected impact of the 1115 waiver on Florida that was presented by national experts. Projections are based on the methods use by the national experts and are neither endorsed nor disputed by the Institute. The Institute regularly analyzes data for community agencies upon request.

These eight briefs outline the key features of Florida's Medicaid program as well as the potential impact on Duval County of a waiver that could alter the funding and administration of the state's Medicaid program.

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1115 Waiver Brief #1: Medicaid Basics

Medicaid is a national health care program created in 1965. The objectives of the program are to:

- Provide broad health care coverages to certain lower income populations;
- Offer special community-based coverages for certain disabled and elder populations;
- Extend supplemental coverage to lower income Medicare beneficiaries; and
- Offset the high costs of institutional care for lower and moderate income Floridians.[1]

Eligibility is strict and uses income and assets to determine eligibility. Medicaid is available to the following groups if they (or their family) earn low income: 1) parents, caretaker relatives and pregnant women 2) children and teenagers, 3) aged (elderly), and 4) blind or disabled persons.

The Medicaid program is funded by state and federal funds. In Florida, 62% of Medicaid costs are paid with federal dollars. Matching federal funds are contingent upon the state's continued compliance with the federal laws and regulations.[2] All states must provide the following services to their Medicaid enrollees:[1]

Advance Nurse Practitioner Services	Hospital Outpatient Care	Portable x-ray services
Early and Periodic Screening, Diagnosis and Treatment of Children (EPSDT)	Independent Lab	Rural Health
Family Planning	Nursing Facility	Transportation (in limited cases)
Home Health Care	Nurse Midwife Services	
Hospital Inpatient Care	Physician Services	

Each state also can provide optional services. Florida has chosen to provide 30 services in addition to the 15 mandatory services. Some of those 30 include:

Community Mental Health	Hospice Care	Primary Care Case Management
County Health Department Clinic Services	Physical Therapy	School-based Services
Healthy Start Services	Prescribed Drugs	State Mental Hospital Services

Not all providers accept Medicaid. However, if a provider does, they must accept Medicaid payment as payment in full. Medicaid has a set fee for each individual type of service. A recent study has shown that Medicaid reimbursement remains too low to be a feasible payer option for some providers. Decreasing medical reimbursement will make the problem worse and could make it much harder for Medicaid recipients to get quality health care.[3]

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[1] Agency for Health Care Administration "A Snapshot of Florida Medicaid" www.fdhc.state.fl.us/Medicaid/
[2] Agency for Health Care Administration "Florida Medicaid Summary of Services, FY 2003-2004" July 2003.
[3] Stephen Zuckerman, Joshua McFeeters, Peter Cunningham, and Len Nichols. "Changes In Medicaid Physician Fees, 1998– 2003: Implications for Physician Participation" Health Affairs 23 June 2004.

Medicaid vs. Medicare

Medicaid is often confused with Medi*care,* the other federal program which provides hospital and medical insurance for adults 65+ or to those under 65 but who have end-stage renal disease or are disabled, regardless of their income.

- Eligibility for Medicaid depends on age, disability or family status *and* on an individual's (or family's) income and resources; while eligibility for Medicare depends on age or disability only.
- Benefits under Medicaid and Medicare vary, for example, Medicaid covers nursing home care while Medicare does not (or only does on a very limited basis).
- State and federal governments fund Medicaid, and its optional benefits vary from state to state. Medicare is funded entirely by the federal government and its benefits are the same in all 50 states.
- Medicaid has income limitations; Medicare does not. This means that Medicaid is a "means tested" program.

Containing Costs of Medicaid through Waivers

The federal government has made minor changes to the basic structure of the Medicaid program since its inception 40 years ago. Meanwhile, states have a number of options to modify the program, including a waiver process that allows substantial departures from the initial federal requirements of the Medicaid program and states have shown heightened interest in waiver activity in recent years. The federal government has implemented various changes to the Medicare program over the past 40 years, most recently with the addition of a national prescription drug benefit.

Currently, the state of Florida is considering a number of changes to its Medicaid program in an attempt to contain costs. There are several options for states trying to contain costs:

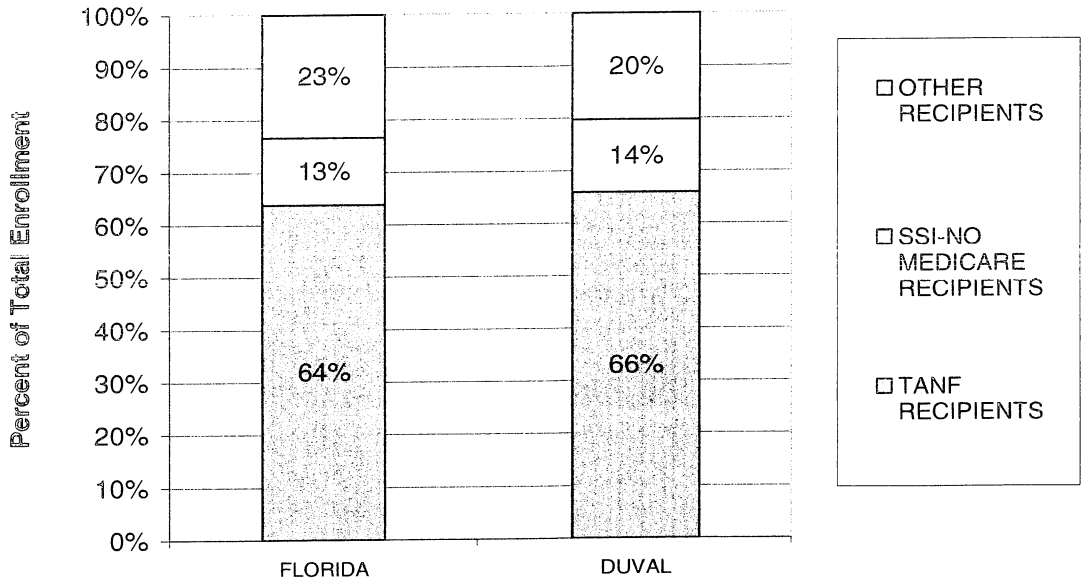
- decrease provider reimbursement
- adjust eligibility requirements (within limits)
- modify or decrease the number and type of optional services the state provides, or
- apply for a waiver to enable a state to make more substantial changes to the structure of the Medicaid program.

Florida currently has 13 waiver programs, which allows the state to modify its Medicaid program in various ways.

1115 Waiver Brief #2: Duval County Medicaid Enrollees

The demographics of Duval County's Medicaid enrollees seem to mirror closely those of the state of Florida. Current enrollment data from June 2004 was obtained from Florida's Agency for Health Care Administration (AHCA), the state agency that develops and carries out policies related to the Medicaid program. In June 2004, Duval County had 99,297 Medicaid enrollees. This is approximately 4.8% of Florida's 2.1 million Medicaid enrollees, down from 5.1% in 2001.[4] Those who are eligible for Medicaid can be classified by various characteristics such as age, employment status, marital status, income level, and disability status, categories by which eligibility is determined. The graph below shows Duval County's Medicaid recipients are very similar to the state's recipients.

Florida vs. Duval County on Enrollment by Enrollee Type - TANF, SSI, and Others (Based on June 2004 Data on the State and County)



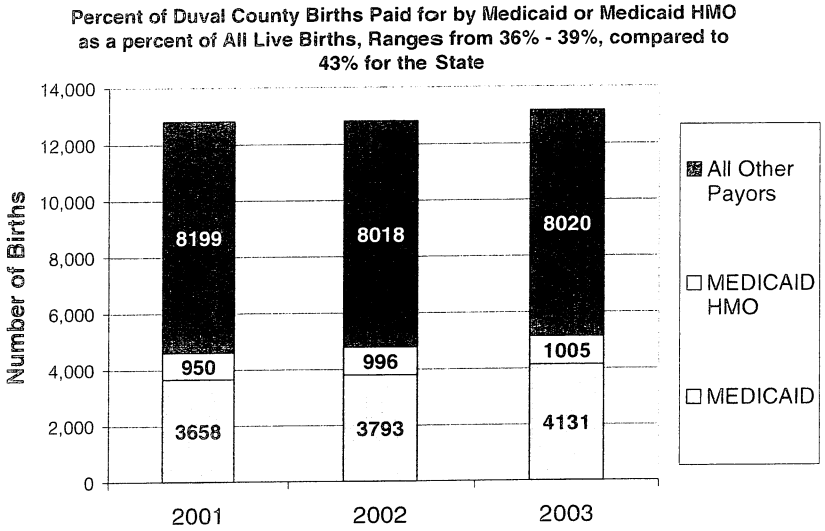
What are SSI and TANF?

"SSI" stands for Social Security Income recipients. SSI is a Federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people, who have little or no income and it provides cash to meet basic needs for food, clothing, and shelter. Source: www.ssa.gov/notices/supplemental-security-income/

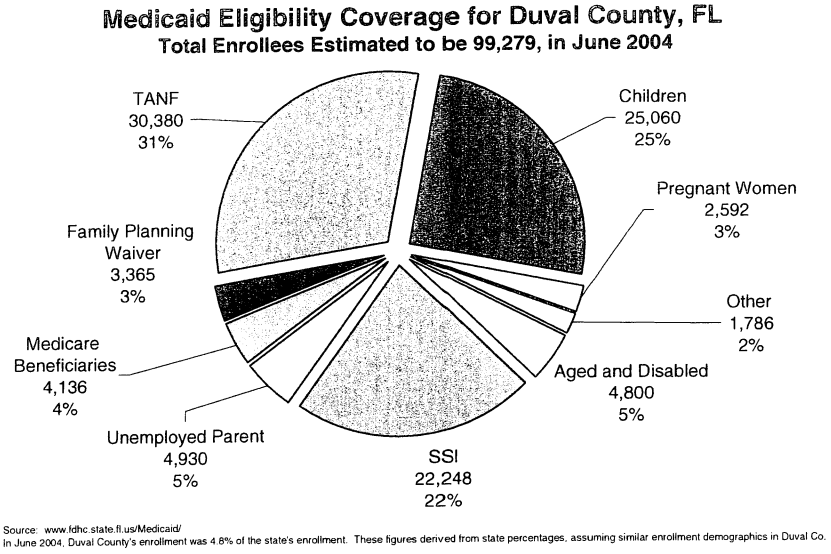
"TANF" stands for Temporary Assistance to Needy Families, which is a program that provides assistance and work opportunities to needy families. The federal government grants states federal funds and wide flexibility to develop and implement their own welfare programs. Source: www.acf.dhhs.gov/programs/ofa/

[4] Agency for Health Care Administration Website http://www.fdhc.state.fl.us/Medicaid/MediPass/reports.shtml

It is estimated that 43% of all Florida births are paid for by Medicaid.[5] Duval County data shows a similar percentage ranging from 36% to 39% (2001-2003) of all births in the county being covered by Medicaid.[6]



In the pie chart below, Duval County's Medicaid enrollees are divided by eligibility categories, "TANF" and "Children" being the two largest sub-groups. It is important to note there are children contained in the TANF counts, since TANF is a cash assistance program for children and their families with low income. Those who qualify for TANF automatically qualify for Medicaid, although that does not mean they are automatically enrolled; the recipients must enroll themselves in the Medicaid program. There is a separate piece of the pie chart designated only for children. These children often exceed the income limits of TANF, but qualify for Medicaid on their own (without their parents) based on other criteria.



[5] Agency for Health Care Administration, Hospital Inpatient Discharge Data Files.
[6] Agency for Health Care Administration, Hospital Inpatient Discharge Data Files extracted August 20, 2004.

Medicaid is a "means tested" program, which means that measures of income and assets are used to determine eligibility for Medicaid benefits. As a general guide, those who determine eligibility use specific percentages of the federal poverty level (FPL) to determine if particular groups (children, pregnant women, aged, blind and disabled) are eligible for Medicaid benefits. Listed below is the 2004 FPL:

2004 Health and Human Services **Federal Poverty Levels**[7]	
Size of Family Unit	48 Contiguous States and D.C.
1	$ 9,310
2	12,490
3	15,670
For each additional person, add:	3,180

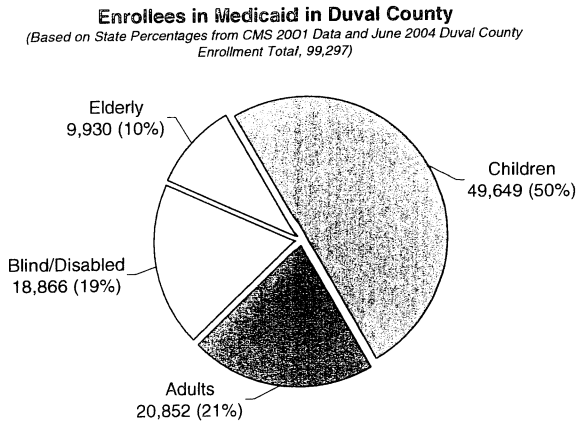
The FPL levels used to determine eligibility for various groups are listed in the chart below:

Income Eligibility Levels for Medicaid Enrollment Groups as a Percent of FPL for 2000, 2001, and 2003

Enrollment Group	FPL%
Pregnant Women	185
Non-Working Parents	24
Working Parents	63
Supplemental Security Income	74
Aged, Blind and Disabled (OBRA '86)	90
Medicaid Infants Ages 0-1	200
Medicaid Children Ages 1-5	133
Medicaid Children Ages 6-19	100

http://www.statehealthfacts.org Kaiser Family Foundation

Fifty percent of all Florida Medicaid recipients are children. Based on this, we can estimate that 50% of Medicaid enrollees in Duval County are children as well. These children could qualify for Medicaid on their own or with their families through the Temporary Assistance to Needy Families (TANF) program.



[7] *Federal Register*, Vol. 69, No. 30, February 13, 2004, pp. 7336-7338. US Department of Health and Human Services http://aspe.hhs.gov/poverty/04poverty.shtml

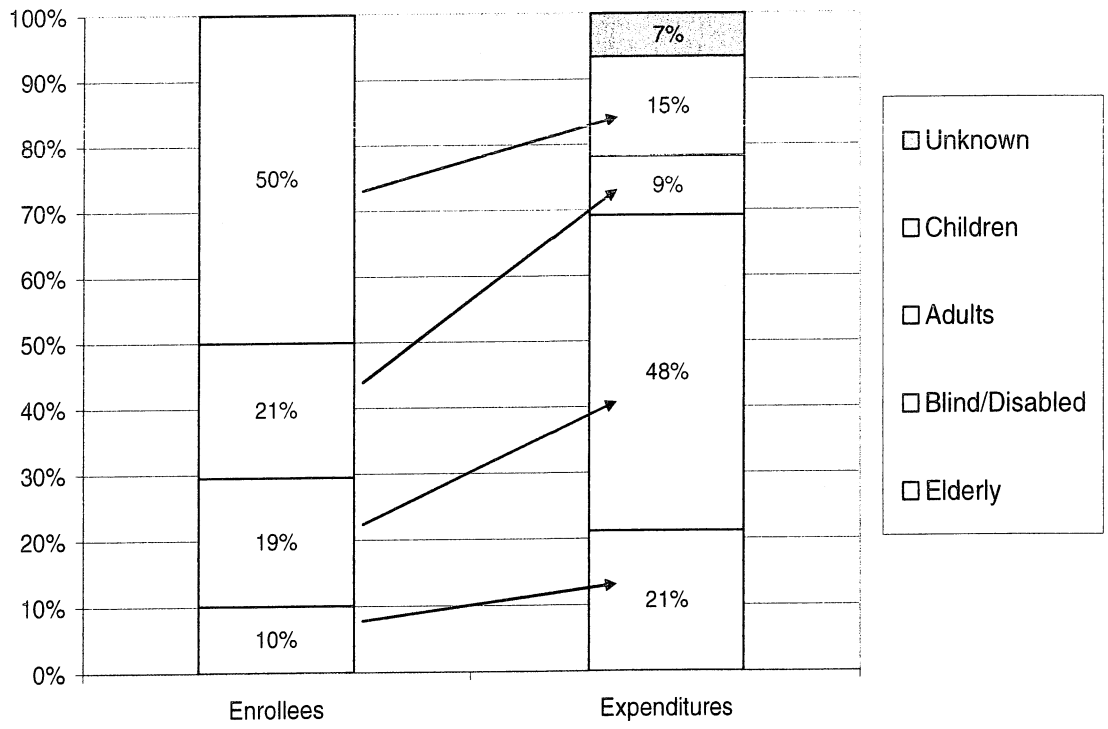
1115 Waiver Brief # 3: Enrollment and Expenditures by Beneficiary Type

The four low-income groups eligible for Medicaid benefits are: 1) adults (usually pregnant women), 2) children and teenagers, 3) aged (elderly), and 4) blind or disabled persons.

Children make up 50% of the all Medicaid enrollment in Florida, but account for only about 15% of Florida's Medicaid expenditures. Adults on Medicaid make up 21% of those enrolled and account for 9% of expenditures. Forty-three percent of all births in Florida are covered under the Medicaid program[8] – in Duval County 39% of all births were paid for by Medicaid. The two groups representing the smallest proportion of Medicaid enrollees, blind or disabled and the elderly, constitute 29% of the enrollment population, yet account for 69% of all Medicaid costs in Florida, due to their special health care needs. We can estimate, based on similar enrollment (see Brief #2), that like expenditures occur in Duval County.

Florida's Medicaid Enrollees and Expenditures, 2001

Alker, J. "Florida's Medicaid Waiver: What Could It Mean" Georgetown Health Policy Institute. Presentation on August 11, 2004.
Data from Centers for Medicare and Medicaid Services MSIS data, 2001.



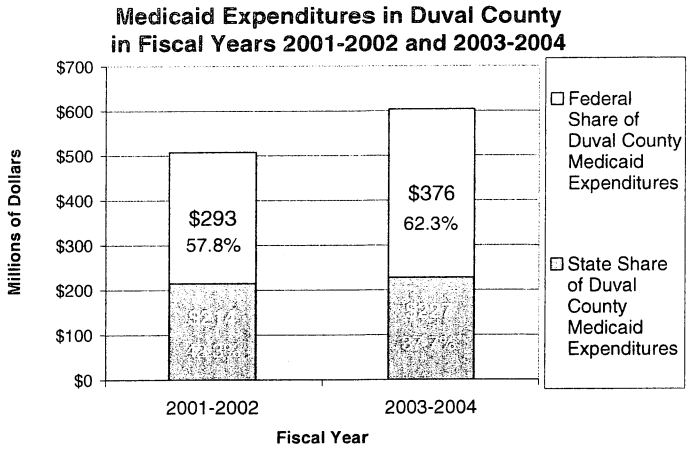
[8] Presentation by Joan Alker, July 12, 2004 Medicaid Symposium, Orlando, FL. Source: Georgetown Health Policy Institute Analysis.

1115 Waiver Brief #4: Federal Contributions to Duval's Medicaid Expenditures

The state of Florida intends to apply for a comprehensive Section 1115 Medicaid waiver. This waiver, if approved, will change the way the Florida Medicaid program is funded by the federal government. Currently, in Florida (and most other states), Medicaid is an open-ended federal-state matching program. The federal government contributes a fixed percentage – approximately 62 percent in 2003 in Florida -- of the state's costs; however the exact percentage it contributes varies from year to year and is calculated using a formula that takes into account the state's per capita income relative to the national per capita income. In Florida, it was lowered to 59% on July 1, 2004.

All Section 1115 waivers are required to be "budget neutral" for the federal government. This is to ensure that the federal government does not spend more under a waiver than it would have in the absence of a waiver. The federal government has typically enforced budget neutrality agreements by using a "per capita" cap – this caps the amount of federal matching dollars per person but not the overall level of federal spending. Some experts contend that a "global" cap – which creates an overall, firm limit on Florida's federal Medicaid funding -- could be imposed .[9] Under any Section 1115 waiver agreement, local communities will see their Medicaid funding limited in some way – a global cap would establish a clear limit on federal funding.

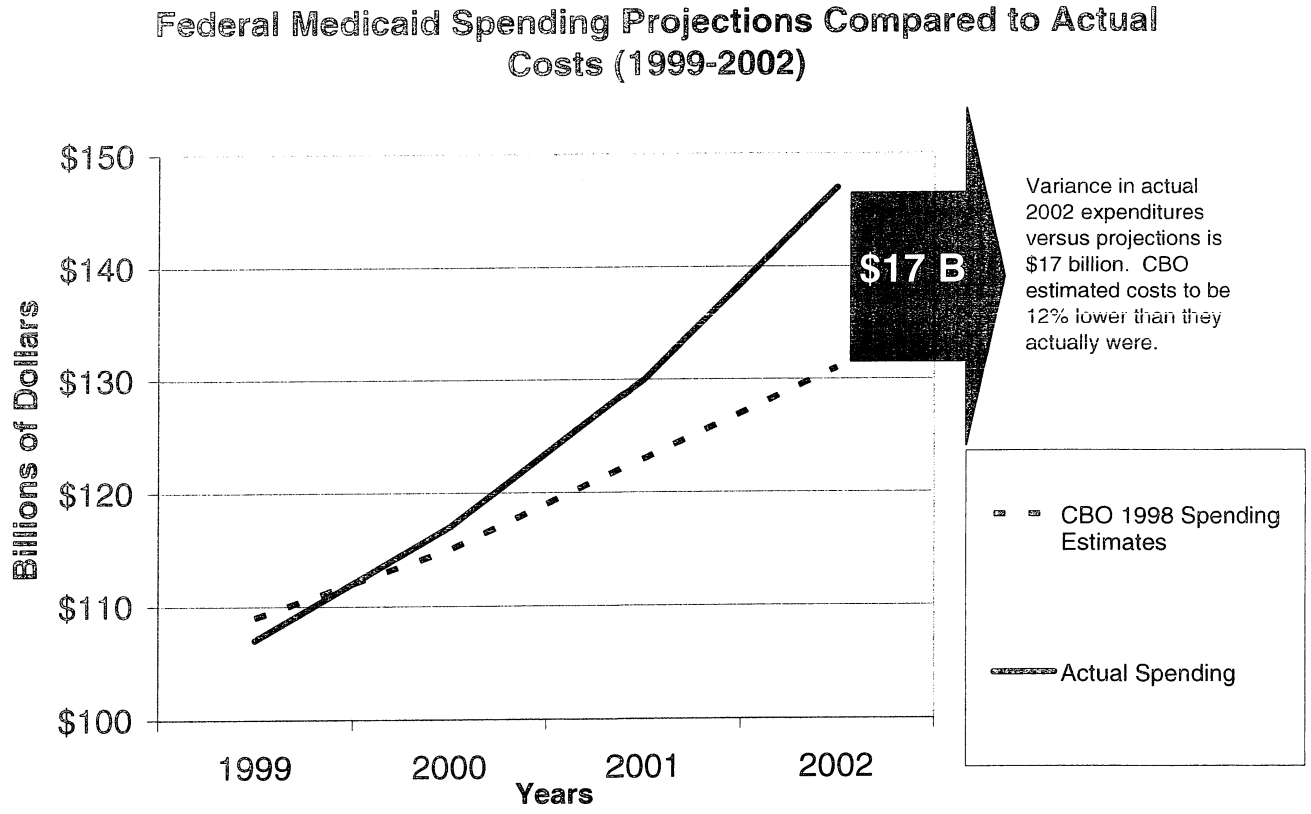
The waiver's financing agreement would be determined prior to the 5-year waiver period (2005-2009) based on future cost and enrollment *estimates*. The chart below displays recent state and federal contributions to the Medicaid expenditures in Duval County. In the 2001-02 Fiscal Year, the federal government contributed 57.8% of the county's Medicaid costs, nearly $300 million. In Fiscal Year 2003-04, the federal government contributed 62.3% of the total cost, for a federal share of $376 million. Currently, for any qualifying health services that Florida provides to an eligible person, Florida is assured that the federal government will share the cost.[10] This assumption will change should this global federal cap be implemented.



[9] Alker, J. and Portelli, L. "What Could a Waiver to Restructure Medicaid Mean for Florida?" Florida's Health at Risk Published by the Winter Park Health Foundation. April 2004.

1115 Waiver Brief #5: Projecting Future Costs of Medicaid

If the Center for Medicare and Medicaid Services approves the 1115 waiver application to cap federal funding to the state of Florida, the state will receive a pre-determined, set amount of federal funding based on best estimates of what Florida's Medicaid costs will be over the next 5-year period. However, projecting future Medicaid costs is a complicated task. The Congressional Budget Office (CBO) is part of the legislative branch of the federal government whose purpose is to do just that: make economic forecasts and projections for Congress.[10] Although mandated to make these projections, it frequently errs in estimating these future costs. In 1998, the CBO underestimated 2002 Medicaid expenditures by 12%, or $17 Billion.[11]



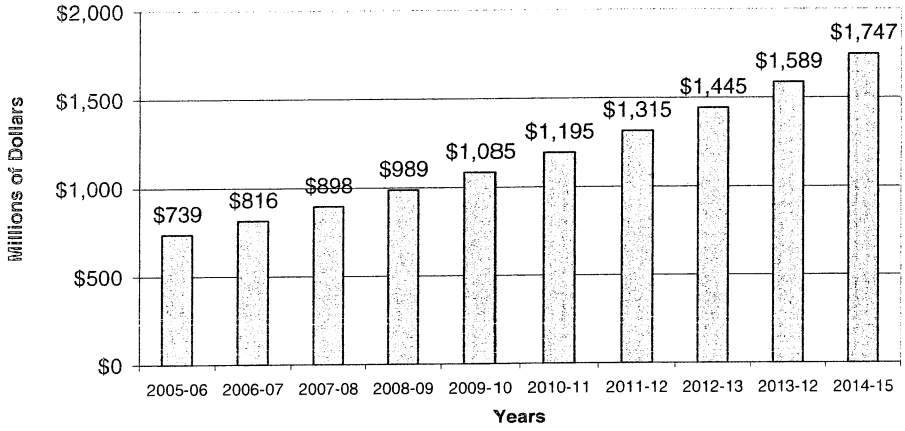
CBO Economic and Budget Outlook 1998, CMS Website - Medicaid Expenditures 1999-2001.
Chart replicated and modified from Joan Alker's Presentation on August 11, 2004 "Florida's Medicaid Program: What Could a Waiver Mean?"

[10] Congressional Budget Office Website www.cbo.gov
[11] CBO Economic and Budget Outlook 1998, CMS Website - Medicaid Expenditures 1999-2001.

1115 Waiver Brief #6: Future Medicaid Costs for Duval County

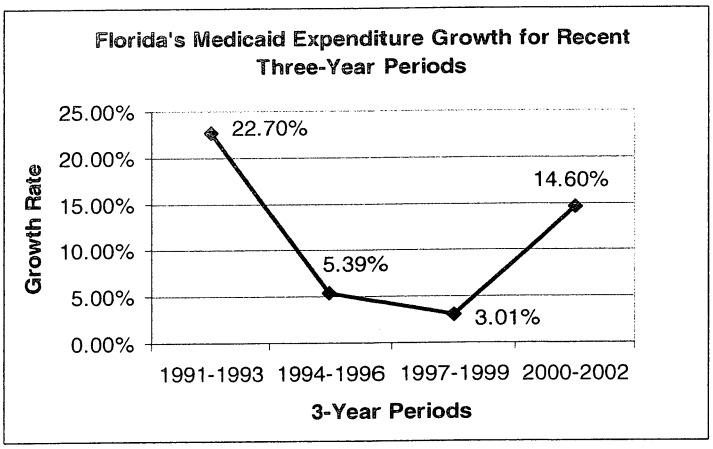
Future Medicaid expenditure estimates for Florida and Duval County have been made, but estimates are frequently inaccurate. Current estimates of Medicaid expenditures in Duval County are shown below. Costs for Duval County are estimated to be a proportion of Florida's costs; at this time, costs for Duval County are estimated to be 4.8% of the state's costs based on the fact that 4.8% of Medicaid enrollees reside in Duval County. These cost projections assume a steady 10% growth in expenditures each year. This growth rate takes into account both the increase in health care costs on a per capita basis, as well as the cost increases associated with increases in Medicaid enrollment.

Projected Future Growth in Medicaid Service Expenditures for Duval County*



* Projected growth in expenditures for Duval County was derived from the overall state's expenditure projections. Duval County is estimated to be responsible for 4.8% of the state's total Medicaid expenditures.

The bar chart above shows a smooth upward trend in expenditure increases. However, history has shown that expenditure growth in Florida overall has been much more erratic than the linear trend projected above.[12]

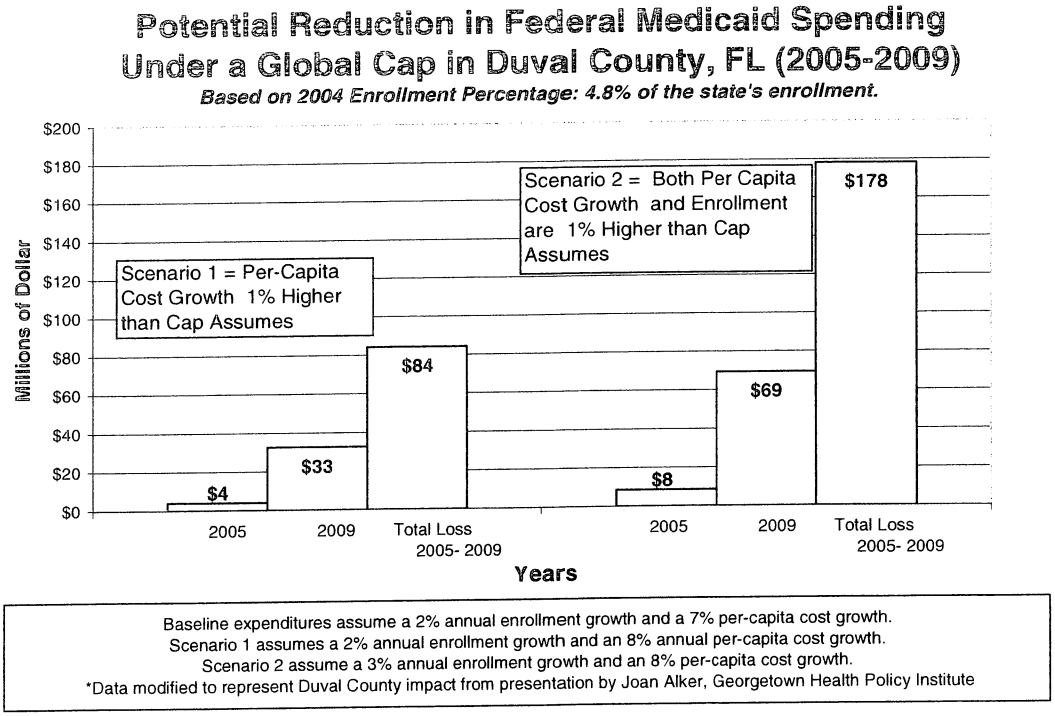


[12] Presentation by Joan Alker, July 12, 2004 Medicaid Symposium, Orlando, FL. Source: Georgetown Health Policy Institute Analysis.

1115 Waiver Brief #7: Losses in Federal Contributions for Duval County

Should the expenditure estimates used to determine the global cap amount be incorrect, even by the slightest percentage point, Florida would be solely responsible for any additional costs above the cap.[13] In essence, additional costs would be paid for by the state at 100%, in contrast to the approximate 40% the state would be responsible for without the waiver. Because the state budget tends to be tight, Florida would need to consider either reduction in payments to providers or reduction in optional benefits to patients, both of which can compromise the quality of care enrollees receive.

Below is a chart that shows the federal funding dollars that Duval County would lose should Florida and the Center for Medicare and Medicaid Services miscalculate the costs for the waiver period, 2005-2009. Under "Scenario 1," the county would suffer an $84 million reduction in federal Medicaid spending, if Florida was to underestimate the per-capita cost growth by 1%. Under "Scenario 2," should the state underestimate both the per-capita cost growth and the enrollment growth by 1%, the losses for Duval County could reach $178 million.[14] It is not clear how the county will adapt to this loss. Either the county could be required to increase income, such as tax revenue, or services will be reduced for Duval County Medicaid recipients. This does not take into account the economic losses for the community at large in terms of jobs and income to local industry. The economic impact is discussed in 1115 Waiver Brief #8.



[13] Joan Alker. Presentation "Florida's Medicaid Program: What Could a Waiver Mean?" August 11, 2004. Georgetown Health Policy Institute.

[14] Data modified to represent Duval County impact from presentation by Joan Alker, Georgetown Health Policy Institute, "Florida's Medicaid Program: What Could a Waiver Mean?" August 11, 2004.

1115 Waiver Brief #8: The Potential Economic Impact of a Global Cap on Medicaid Funding

By limiting (or capping) the amount of dollars Florida (and Duval County) can receive from the federal government based on inaccurate future cost estimates, the loss of funding could translate into lost business and increased unemployment for Duval County's economy.

In a report published in October 2003, it was estimated that the current open-ended Medicaid match supported 120,950 jobs in the state of Florida, creating $4.3 billion in income and $8.7 billion in business activity.[15] Each federal Medicaid dollar generated $2.7 dollars in income and business activity. As demonstrated in brief #4, the federal government's match was $376 million in Duval County for Fiscal Year 2003-2004. This means the open-ended federal matching program brought $1,015 million in income and business activity to Duval County and the city of Jacksonville. "Business activity" means the value of all goods and services produced by Duval County's industries in a given time period, or the value of all wholesale and retail sales plus inventories.

According to this study, Duval County had a total of 6,899 jobs ($197 million in income) supported by the federal government's matching of Medicaid costs in 2001-2002.[16] This is not to say that all of these jobs will be lost if the 1115 waiver is approved, but what it does say is these jobs will not be permitted to grow at the rate necessary should Medicaid expenditures and services in the county need to expand beyond what the cap provides for, and beyond what the state can afford to fund. The potential cap in federal funding would strictly limit these job opportunities.

Savings that the state of Florida proposes will happen with the use of this 1115 waiver could actually end up creating greater costs for the state and Duval County in terms of lost revenue, jobs, and income if a global cap is imposed through this waiver process.[16]

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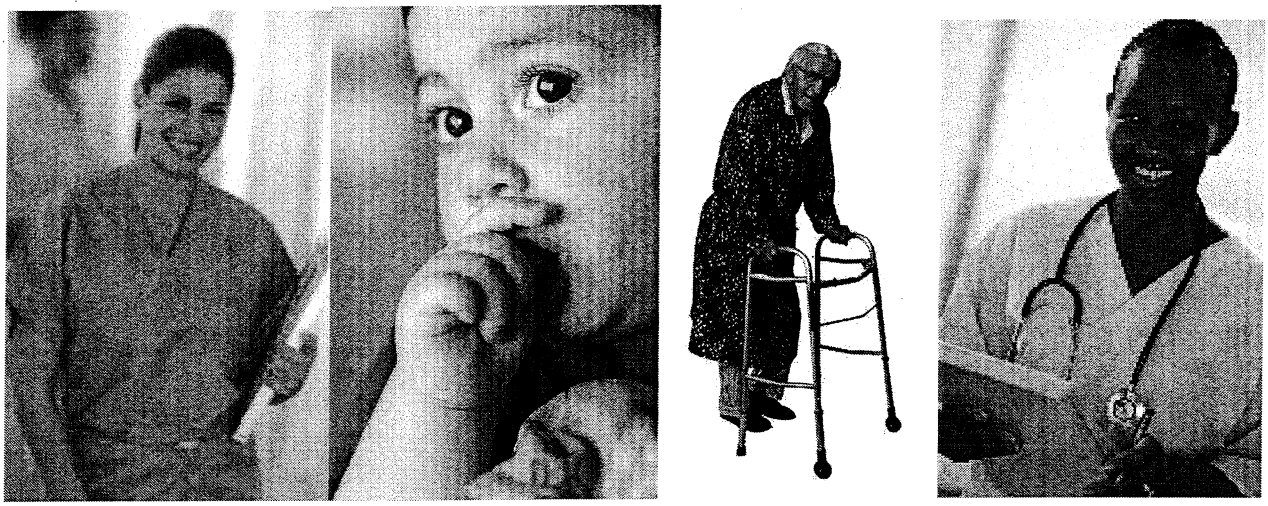
Conclusion

The First Coast Coalition for the Uninsured remains dedicated to keeping citizens and key policy makers informed about the status of this 1115 Medicaid waiver. Capping federal funding through an 1115 Medicaid waiver could have a significant impact on Duval County and its residents, Medicaid recipient or not.

- Benefits could be cut for Medicaid beneficiaries causing them to lose valuable health care services.
- Medicaid providers could be very adversely affected.
- Some experts contend that a cap on federal funding could also have a devastating effect on the County's economy.
- Proponents of a cap cite the potential to make much needed reforms in the system to make it more efficient, with few anticipated changes to the beneficiaries or providers.

Therefore, it is important to remain informed on this issue and other issues that our lawmakers propose so we may ensure good ethical and financial decisions are being made on behalf of residents of Duval County and the state of Florida.



PRESCRIPTION FOR HEALTH CARE REFORM

18

SEIU Stronger Together

Let's Get Reform RIGHT medicaid

This report was written and produced by the Research Department at

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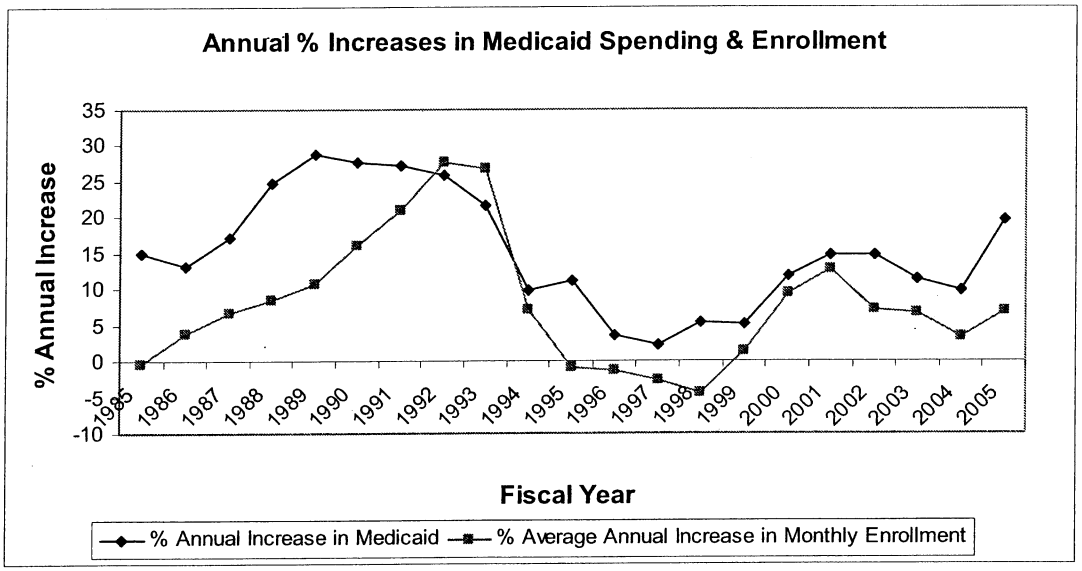
THE SEIU PRESCRIPTION FOR HEALTH CARE REFORM

Rising health care costs threaten all Florida residents from children to retirees, from those with private insurance to those who depend on Medicaid. As Florida's largest health care workers' union, members of the Service Employees International Union have the unique experience of being both providers and consumers of health care. From this perspective, SEIU knows the importance and impact health care reform will have on all Floridians. If reform is done hastily without focus on the real problems, the attempt to save costs will only shift costs. Much attention has focused on the growth in the Medicaid program. Medicaid growth, however, is only symptomatic of the decline in employer provided health insurance and the rapid rise in health care costs. These are the real problems demanding real solutions

Increased Medicaid Enrollment

Medicaid enrollment is a function of the economy. As quality jobs become less available, the number of people without access to affordable health care coverage increases and therefore, Medicaid enrollment and Medicaid spending increase. In fact, the Winter Park Health Foundation found that 65 percent of the increase in Florida Medicaid costs between 1999 and 2004 were due to increased enrollment[1]. As the chart below shows, the percentage increases in Medicaid spending have mirrored the percentage increases in enrollment.



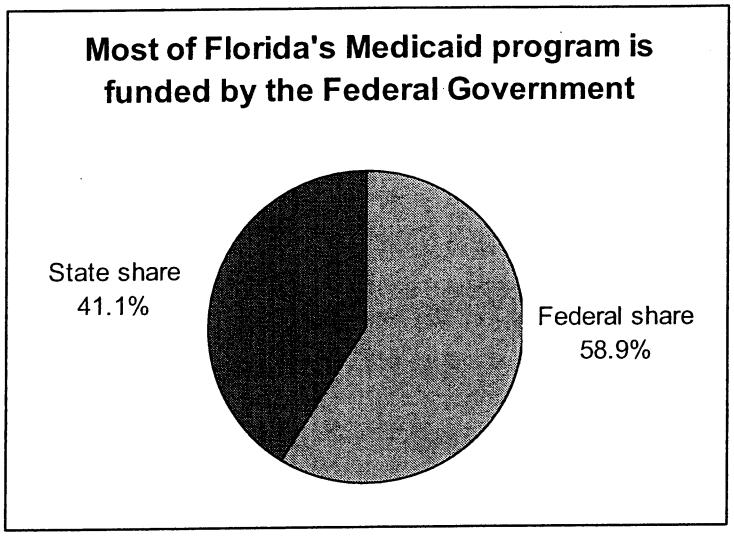
Source: Medicaid Services data from AHCA presentation, 11/2004

Rising Health Care Costs

In the same way, the rising health care costs that plague the private sector also plague the Medicaid program. Both the private sector and Florida Medicaid experienced double-digit increases in prescription drug costs between 1998 and 2003.[2]

However, Florida's Medicaid program is better able to mitigate the impact of these health care challenges than the private sector because the federal government matches Florida's state Medicaid spending and the Medicaid program is more efficient than private health care.

While much of the discussion surrounding Medicaid reform focuses on Medicaid's drain on the budget, Medicaid actually produces revenue for the state. The federal government pays a majority of the share of the state's spending on the Medicaid program. For every dollar spent on Florida's Medicaid program, approximately fifty nine cents are from the federal government.[3] Any reduction in Medicaid expenditures leads to an equal reduction in federal matching funds.



Source: Kaiser Family Foundation FY2005 Florida FMAP

Medicaid is more efficient at controlling costs than the private sector. For example, between 2000 and 2002, Florida Medicaid expenditures increased on average by 13.6 percent[4] while health insurance premiums for small Florida employers grew 16 percent in 2000, 24 percent in 2001 and almost 30 percent in 2002.[5]

Because health care, especially Medicaid, plays such an important role in Florida's economy, the cost, quality and access challenges can and must be addressed immediately. SEIU believes the following principles should guide decision makers:

1. Increase the federal government's share of state Medicaid spending
2. Invest in care management programs
3. Utilize the negotiating power of the state to decrease the costs of prescription drugs, supplies and durable goods
4. Expand access to affordable health care coverage
5. Increase quality to reduce expensive complications
6. Reduce health disparities

SEIU recommends the following proven reform initiatives to begin saving health care dollars immediately:

Reform	Estimated savings
INCREASE FEDERAL SHARE	*See page 4*
Track all claims from dual eligibles to ensure Medicaid is the payor of last resort	$55 million
Encourage Medicaid recipients who qualify to enrolled in Medicare	$32 million - $45 million
CARE MANAGEMENT PROGRAMS	*See pages 4-5*
Expand Medicaid care management programs	$49 million – 161 million
Expand the Provider Service Network Model	$526 per enrollee per year Depending on level of expansion, $71.6 million to $381 million.
BETTER PURCHASING	*See pages 6-7*
Negotiate better prescription drug prices with pharmacies	$96 million - $175 million
Increase use of generics when effectiveness is the same as brand name	$219 million
Require transparency and increased competition for Medicaid suppliers	*Greater choice and lower costs for Medicaid providers and recipients*
EXPAND ACCESS	*See pages 7-8*
Duplicate county-based indigent care programs such as Hillsbourgh County	$536 million - $1.4 billion
IMPROVE QUALITY	*See page 8*
Implement 2.9 nursing home safe staffing standard	*Reduction in lawsuits and staff turnover*
Enact hospital safe staffing standard	*Reduction in expensive complications and mortality*
Total estimated savings	**$1.06 billion - $2.43 billion**

Increase the federal government's share of the state Medicaid budget

Currently, Florida has approximately 377,000 Medicaid enrollees who are eligible for both Medicaid and Medicare benefits.[6] Because of the high number of dual eligibles, Florida has the opportunity to shift more costs to the federal government by ensuring Medicaid is the payer of last resort and encouraging Medicaid enrollees who are eligible for Medicare to enroll. SEIU recommends the state legislature:

1. Ensure Medicaid is the payor of last resort
The federal government has established a procedure for states to recover monies spent on Medicare enrollees for services covered by Medicare. By implementing a stronger claims review process, Connecticut was able to save approximately $200 million over 17 years on its approximately 83,000 dual eligibles. This amounted to approximately $142 per enrollee per year. Extrapolating that out to Florida's over 390,000 dual eligible enrollees, potential savings could be at least $55 million per year.

2. Assist Medicaid recipients with end stage renal, ALS, muscular dystrophy, and multiple sclerosis with applications for Medicare
In Washington, the Lewin Group estimated that twenty to forty percent of Medicaid clients with chronic diseases would become Medicare eligible if they were to apply.[7] In Florida, currently 2,520 MediPass enrollees have end stage renal disease.[8] Approximately between 1,260 and 2,520 people with multiple sclerosis are on Medicaid.[9] In 02-03, Medipass spent more than $990 million on 113,818 beneficiaries with chronic illness averaging about $8,702 per person with chronic illness.[10] Assuming that none of those with end stage renal or multiple sclerosis are currently on Medicare, the state would save, on average, between $32,893,560 and $43,858,080.

3. Commission a study on Medicaid services provided to individuals who qualify for benefits through Veterans Administration
Currently, there are 1.8 million veterans living in Florida – many in need of long term care services. AHCA should study how many veterans are currently on Medicaid and working with the Florida Department of Veterans Affairs develop programs to ensure veterans are utilizing all veterans' health care services prior to enrolling in Medicaid.

Invest in care management programs

According to the November 2000 Estimating Conference, about one-third of Medicaid enrollees, who are chronically ill, account for 90 percent of total Medicaid spending and 90 percent of spending for prescription drugs.[11] Care management initiatives are a tool to rein in health care costs for the most expensive Medicaid enrollees by increasing positive health outcomes through disease education, care management, and best practice guidelines. The state Office of Program Policy Analysis and Government Accountability (OPPAGA) has reported that for every $1 spent on disease management, $1.46 has been saved.[12] However, disease management programs have not reached all eligible participants. According to OPPAGA, only 25 percent of eligible participants received disease management services.[13] SEIU recommends the state legislature:

1. Expand access to care management programs

Already within Florida, disease management programs have netted significant costs savings. According to AHCA, the MediPass disease management program has produced a 5 percent across the board savings in reduced hospitalizations, emergency room visits and improved clinical outcomes.[14] MediPass spent $990,443,336 million in FY 2002-03 on beneficiaries with chronic conditions.[15] If enrollment in disease management programs were guaranteed, based on these figures, the state could save $49 million a year. The partnership between AHCA and LifeMasters, who has provided disease management services for congestive heart failure in North Florida decreased health care costs for participants by 16.3 percent.[16] If all vendors were held to this standard, and all eligible beneficiaries participated, the state could save $161 million a year.

2. Reduce administrative costs through better contracting

Florida has spent over $76 million in administrative costs for eight of the 11 disease management vendors since 1999.[17] Today, only two of those disease management programs are still utilized by the state.[18]

3. Ensure health care professionals are included in the design of clinical objectives

One of the important components of a care management initiative is getting health care professional buy-in. As North Carolina has, Florida should create a clinical leadership group to help develop protocols for care management programs.[19]

4. Guarantee care management participation for persons with chronic illness for one year

Loss of Medicaid benefits or difficulty tracking participants were two challenges to increasing care management utilization rates.[20] If the state guaranteed Medicaid eligibility for at least one year if enrollees participated in care management programs, the state would see increased utilization of care management programs and lower costs associated with chronic illnesses.

5. Expand the provider service network model

A Provider Service Network (PSN) uses health care resources more efficiently because it is able to engage PSN Medicaid enrollees directly in their health care maintenance and provide disease management programs. For example, as a participant in the South Florida Community Care Network (SFCCN)[21], Jackson Memorial Hospital offers programs for diabetes, AIDS, asthma, high-risk pregnancies, and will soon start programs for sickle cell and congestive heart failure.[22] The PSN had about 19,000 enrollees as of March 2003 and saved $30 million in the first three years of the program.[23] If PSNs were expanded to include other fee-for-service recipients or MediPass enrollees, using these figures, the state could save $526 per person per year. Currently, 1,362,154 Medicaid enrollees are enrolled in either MediPass or Fee-for-Service.[24] If provider service networks could be expanded to serve just ten percent of this population, the state would save $71.6 million per year. If provider service networks were expanded to serve all of the MediPass population, the state could save $381 million.

5. Standardize evaluation and reporting of care management programs

AHCA and OPPAGA have already identified the models that should be used to standardize outcome analysis and reporting.[25] This standardization will save in evaluation costs and the state to have a much clearer picture of how and where the state is saving money.

Utilize the negotiating power of the state to decrease the costs of prescription drugs, supplies and durable goods.

The cost of prescription drugs has been one of the main drivers of health care spending and increases in Medicaid. Yearly percentage increases in prescription drug expenditures have outpaced total increases in Medicaid. In 2004-05, expenditures for prescription drugs consumed eighteen percent of total Medicaid dollars, more than any other service category at a price tag of $2.6 billion.[26] Florida has historically been successful at leveraging the PDL for additional rebates. On the other hand, durable goods and supplies purchasing has been identified by Medicaid beneficiaries as a source of fraud and excessive expenditures. SEIU recommends:

1. Expand drug education through care management services

Currently, AHCA is conducting statewide care management projects related to HIV/AIDS, asthma, diabetes, congestive health failure (CHF), and hypertension for MediPass enrollees. In addition, the Bureau of Medicaid Pharmacy Services is conducting drug education pilot projects for enrollees with mental health, HIV/AIDS, and hepatitis.[27] If successful, AHCA should incorporate the drug education projects into the care management program.

2. Ensure that costs paid to pharmacies, especially big chain pharmacies, reflect the cost paid by the pharmacy to acquire the drug

Currently, Florida reimburses drug ingredient costs at the lower of the average wholesale price (AWP) minus 15.4% of the drug or the average price drug wholesalers pay manufacturers (WAC) plus 5.75 percent.[28] The Office of the Inspector General in the United States Department of Health and Human Services has found that on average, pharmacies bought generic drugs from manufacturers at a national average price of AWP minus 65.93%[29] and brand name drugs at a national average price of AWP minus 21.84%.[30] At Florida's current reimbursement rate of AWP minus 15.4 percent, the state may be paying some pharmacies at least three times more for generic drugs than the pharmacies pay the manufacturers. Florida could address this issue by:

- Changing the pharmacy reimbursement rate to AWP minus 17 percent and save roughly $96 million.
- Changing the pharmacy reimbursement rate to AWP minus 20 percent, the state would save $175 million.[31]
- Adopting the average sales price payment methodology used by Medicare Part D. This methodology is based on what is actually paid for the drug, rather than a price set by the pharmaceutical industry. It is unclear what the cost savings would be, but CMS which is discontinuing the Medicare reimbursement rate of AWP minus 15 percent expects to save millions of dollars.[32]
- Require pharmacies to report what the actual costs of providing drugs to the Medicaid program.

Each of these savings would be lessened by the implementation of Medicare Part D in January 2006. However, Medicare Part D will only affect half of Florida's prescription drug spending.[33]

3. Encourage the use of generic drugs

Even though Florida has a limit of four brand name drugs a month, Florida Medicaid pays on average fives times more for brand drugs than generics.[34] Florida can save money by increasing generic drug utilization for all prescription drugs excluding mental health and HIVS/AIDS drugs

where the effectiveness between generics and brand names are the same. This can be done in the following ways:

- Increase dispensing fee to pharmacists for generic drugs.
- Require the use of generic drugs when available and equally effective. When Idaho's generic drug utilization rate increased, it reduced prescription drug expenditures by 8.3 percent.[35] If Florida accomplished similar savings, the state could save $219 million dollars per year.

4. Increase transparency and accountability in durable goods and medical supply purchasing
The state contracts with numerous vendors to provide services and supplies to Medicaid enrollees. The state should make the contracts and procurement processes clear and accountable by:

- Restricting the use of no-bid contracts.
- Creating opportunities for public input before and during the selection process.
- Releasing the criteria for evaluating bids and the timeline for awarding contracts.
- Conducting consumer surveys of vendors to include in reviews.
- Establishing performance reviews and auditing requirements and report findings to the public.

Additionally, the state should conduct an audit of durable goods and medical supplies purchasing and fraud.

Expand access to affordable health care coverage

As employer-provided affordable health coverage has declined, the number of uninsured has risen dramatically. Nineteen percent of Florida's under 65 population is uninsured.[36] The rising uninsurance rate is a consequence of employers no longer offering living wages or affordable health coverage. Over 50,000 Florida employers have employees receiving Medicaid benefits.[37] Just under half of all Medicaid enrollees have at least one full time worker in their family. [38]

The growing number of the uninsured creates a burden on both the private and public health care market. Because the uninsured deny treatment until they are critically ill, health care for the uninsured is more expensive and less likely to be paid. This results in a cost shift to those who are covered through higher premiums. A vicious cycle is created which forces health care further out of reach for Florida families. SEIU recommends:

1. Duplicate and expand effective county level indigent care programs
One of the most successful and cost-efficient county health care programs in the country is one of Florida's own. Hillsborough HealthCare provides managed health care for 28,000 uninsured county residents whose incomes are at or below the federal poverty level and a Medical Crisis Intervention Program for those with serious medical conditions with incomes above 100 percent of the federal poverty level. Hillsborough County collects a quarter of a cent in sales tax and property taxes to finance its health care plan.[39]

The program has reduced the cost of emergency room care by $10 million and has saved more than $90 million in medical expenses. The county saves approximately $50 million a year in

health care costs.[40] If this program were expanded to the rest of Florida's uninsured population earning less than the federal poverty level, and generated the same cost savings, this program could save the state's health care providers and counties approximately $1.4 billion in medical expenses. If expanded to half of the uninsured population living below the federal poverty level, Florida could save $713 million dollars, or $356 million if a quarter of this population were served.

2. Encourage employers to offer affordable health care coverage

Several options are available to increase health care coverage through employers including:

- Create a statewide group through which individuals, small businesses and the self-employed can purchase private insurance[41]
- Create a standardized health insurance package to be offered by all health maintenance organizations that is made more affordable through state reinsurance[42]

Increase quality to reduce expensive complications

Health care quality in Florida's nursing homes and hospitals is at risk. Numerous studies have shown that staffing levels are the best indicators of quality. Safe staffing lowers infections, complications, mortality rates and even staff turnover. In order to ensure that all Florida residents have access to quality health care, the state must protect patients by enacting minimum safe staffing levels.

1. Fund the statutorily-mandated 2.9 CNA hours per patient per day

In 2001, the Florida legislature passed SB1202 which established 2.9 certified nursing assistant (CNA) hours per patient per day as the minimum nursing home staffing standard. Currently nursing homes are at the 2.6 CNA hours per patient per day level. The final implementation to 2.9 was delayed last year and the Governor's budget proposal this year recommends delaying it again. In order to keep pace with the growing acuity of nursing home patients, the state must implement the 2.9 safe staffing standard.

2. Ensure safe staffing levels in hospitals

Even though studies have confirmed that nurse-to-patient ratios have a direct impact on patient health and mortality, Florida hospitals do not have a safe staffing standard. . A University of Pennsylvania study published by the Journal of the American Medical Association, for example, found a progressively higher mortality rate as the number of patients each nurse had to care for increased. A Harvard University study found that a higher number of nursing care hours were associated with shorter hospital stays, lower infection rates and lower rates of pneumonia. In fact, there is no transparency at all about hospital staffing levels. Senate Bill 1176, and House Bill 1117, currently being considered by the Florida legislature would create this minimum safe staffing standard in Florida.

Reduce health disparities

Through health care reform, Florida has the opportunity to address growing ethnic and geographic health disparities in both chronic illness and health insurance rates.

Disparities in Chronic Illness

Blacks and Latinos are more likely to suffer from a chronic illness.

- A majority of all people with HIV/AIDS in Florida are either black or Latino.
- Accounting for only 14 percent of the state's population, blacks comprise 50 percent of all HIV/AIDS cases. The number of Latinos with AIDS has increased from 12 percent of all AIDS cases in 1988 to 18 percent in 2003.[43]
- The heart disease death rate was 29 percent higher for African Americans than whites.[44]
- At least one in ten black Floridians has diabetes, higher than any other racial group.[45]
- Thirty-eight percent of all adolescents under age 18 hospitalized for asthma were black or black Hispanic.[46]

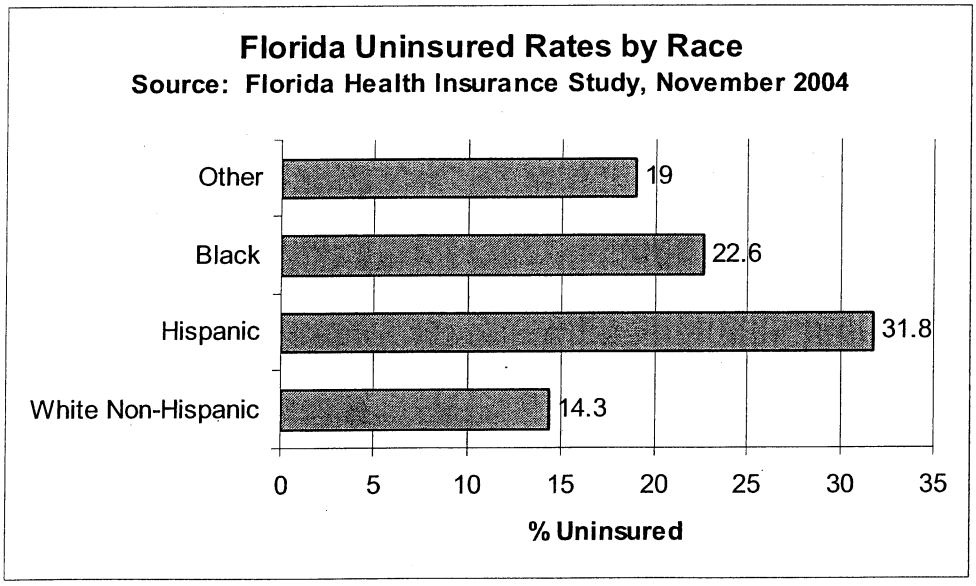
Residents in rural areas have a higher mortality rate than their urban counterparts for diabetes, Alzheimer's, and chronic lower respiratory disease.[47]

Care management programs, if properly targeted, will help reduce health disparities particularly in the areas of asthma, diabetes, HIV/AIDS and heart disease.

In order to be effective, care management programs must be targeted to black and Hispanic Medicaid enrollees. Minority physicians and community clinics must be included in care management design and implementation. Care needs to be culturally competent and language appropriate. The state legislature must ensure that the infrastructure needed to successfully implement the care management model is available across the state. By partnering with community and rural health networks and hospitals, the state can start to reverse these trends.

Disparities in Health insurance

Thirty-two percent of all Latinos under age 65 report being uninsured compared to 23 percent of blacks and 14 percent of whites.[48]



Rural counties in North Florida and near Lake Okeechobee have uninsurance rates higher than the state average at 20.7 percent and 24.4 percent respectively.[49]

Expand coverage in areas of highest ethnic and geographic disparity

As the state begins to prioritize expanding indigent care programs or creating incentives for employer based coverage, those counties that have the highest disparity in insurance must be the initial sites to ensure that those most in need are targeted.

SEIU is committed to securing affordable, quality health care for all Floridians. Only by investing in quality preventative health care, expanding access, and reducing health disparities will the state be able to improve the efficient use of health care dollars without merely shifting the costs to the private market.

ENDNOTES

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